

## PRACTICAL DERMOSCOPYY

### [Translated article] What Wrinkles Actually Hide

#### Lo que la arruga esconde

#### Case presentation

A 70-year-old woman, with no relevant past medical history, presented with a 1-year history asymptomatic lesion on her neck. Upon examination, she showed a 30 mm x 2 mm linear erythematous-brownish plaque, somewhat crusted, located in the depth of a fold on the left side of her neck (Fig. 1).

#### Comment

Dermoscopic findings shown in Fig. 2 are consistent with a non-superficial basal cell carcinoma. Complete excision of the lesion was performed, which confirmed the diagnosis of nodular and micronodular basal cell carcinoma with clear margins.

In our case, clinical differential diagnosis also included the following entities: scar, exogenous pigmentation, inverse pigmented lichen planus, and terra firma-forme dermatosis. Dermoscopy allowed us to establish an early diagnosis of basal cell carcinoma.

Linear basal cell carcinoma was first described in 1985<sup>1</sup> and is most commonly located in the periocular area and the neck<sup>2-6</sup>; the pathogenic mechanism by which the tumor tends to grow along skin tension lines is unknown to this date.<sup>2,3</sup> No specific dermoscopic findings have ever been described for the linear variant of basal cell carcinoma.<sup>2,4,5</sup> A recently published retrospective, descriptive study with 18 tumors of this type has analyzed their dermoscopic features<sup>4</sup>: more than 80% were pigmented, as in our case, a higher proportion than expected perhaps due to the ethnic characteristics of the study patients (mostly Hispanic/Latino) and a difficulty in diagnosing non-pigmented linear basal cell carcinoma that may lead to underdiagnosis.<sup>4,5</sup>



Dermoscopic structures specific to basal cell carcinoma most frequently observed were blue-gray globules, well-focused dots, and maple leaf-like structures<sup>4</sup> (all present in our case).

We wish to mention the utility of dermoscopy to diagnose linear basal cell carcinoma, exclude other diseases that may also present a linear morphology,<sup>4</sup> and more accurately delineate the tumor's extension, as reportedly, tumors have a greater-than-expected subclinical extension.<sup>3,6</sup> Furthermore, dermoscopy can help guide the histological subtype before anatomopathological results become available and classify it as low or high risk, thus allowing for the selection of the most appropriate surgical technique and margins.<sup>2,6</sup>



Figure 1 Clinical case presentation: left cervical area.

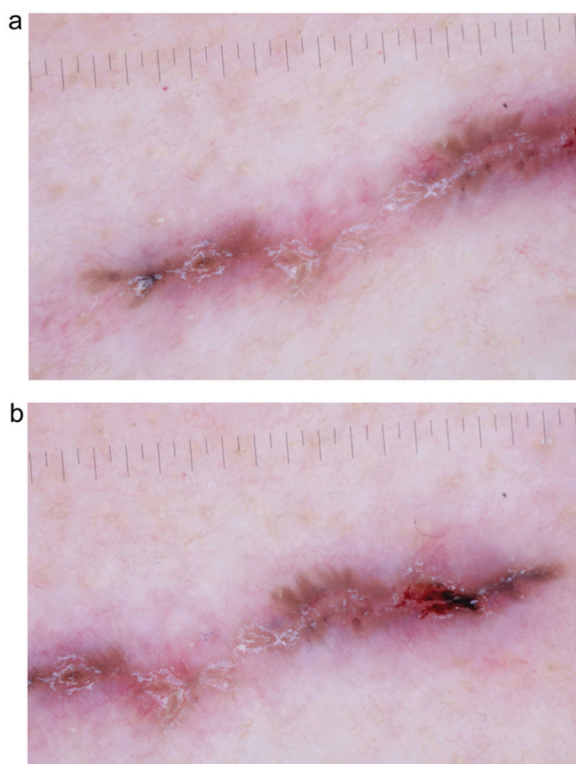
**What is your diagnosis?**

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**Figure 2** Dermoscopic images with polarized light (a and b). Absence of pigmented network. Presence of maple leaf-like structures, dots, blue-gray globules, ulceration, and several erosions.

The most common histological subtype of linear basal cell carcinoma is nodular,<sup>3-6</sup> although it can sometimes be associated with more aggressive subtypes, such as the infiltrative or morpheaform subtypes.<sup>3,4</sup> In retrospective studies and case series, Mohs surgery is the most widely used treatment for linear basal cell carcinoma,<sup>3,4,6</sup> although other authors have also achieved good results with conventional surgery, as in our case, and recommend reserving Mohs surgery for aggressive histological subtypes, or those located in high or medium risk areas (H or M areas).<sup>6</sup>

## Conflict of interests

The authors state that they have no conflict of interests.

## References

- Lewis JE. Linear basal cell epithelioma. *Int J Dermatol.* 1985;24:124–5, <http://dx.doi.org/10.1111/j.1365-4362.1985.tb05396.x>.
- Álvarez-Salafranca M, Ara M, Zaballos P. Dermatoscopia del carcinoma basocelular: revisión actualizada. *Actas Dermosifiliogr.* 2021;112:330–8, <http://dx.doi.org/10.1016/j.ad.2020.11.011>.
- Al-Niaimi F, Lyon CC. Linear basal cell carcinoma: A distinct condition? *Clin Exp Dermatol.* 2011;36:231–4, <http://dx.doi.org/10.1111/j.1365-2230.2010.03908.x>.
- Navarrete-Dechent C, Marchetti MA, Uribe P, Schwartz RJ, Liopyris K, Marghoob NG, et al. Dermoscopy of linear basal cell carcinomas, a potential mimicker of linear lesions: a descriptive case series. *Dermatol Pract Concept.* 2022;12:e2022195, <http://dx.doi.org/10.5826/dpc.1204a19>.
- Alcántara-Reifs CM, Salido-Vallejo R, González-Menchen A, Vélez García-Nieto A. Linear basal cell carcinoma: Report of three cases with dermoscopic findings. *Indian J Dermatol Venereol Leprol.* 2016;82:708–11, <http://dx.doi.org/10.4103/0378-6323.190850>.
- Becher GL, Affleck A, Fleming C, Evans A. Linear basal cell carcinoma occurs most commonly on the lower eyelid. *Clin Exp Dermatol.* 2011;36:311–2, <http://dx.doi.org/10.1111/j.1365-2230.2010.03950.x>.

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