

Microcystic adnexal carcinoma mimicking basal cell carcinoma



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CLINICAL PRESENTATION

A 42-year-old man presented with a 5-year history of an asymptomatic slow-growing papule on the left scapular region. The physical examination revealed a well-defined, 1.2-cm diameter, firm, dome-shaped papule with a white-pinkish center, peripheral small papules with a pearly appearance, and a hyperpigmented outer rim (Fig 1). The initial clinical impression suggested basal cell carcinoma.



Fig 1. Clinical image showing a firm, pearly, dome-shaped papule with a white-pinkish center, cystic structures, and a hyperpigmented outer rim.

DERMOSCOPIC APPEARANCE

Dermoscopic assessment revealed a white structureless central area, white-yellowish clods of variable sizes distributed peripherally, and a brown pigmented outer rim (Fig 2).

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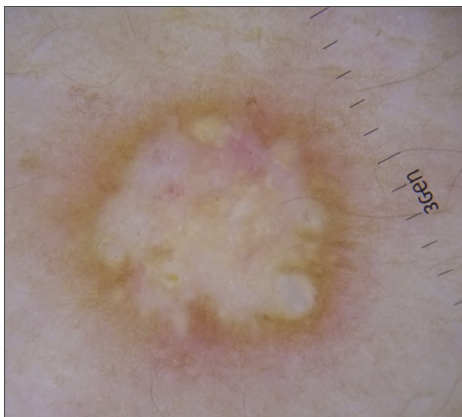


Fig 2. Dermoscopy revealed a white, structureless, central area with white-yellowish clods of variable sizes and perilesional light-brown pigmentation.

HISTOLOGIC DIAGNOSIS

Histopathologic analysis revealed a dermal neoplasm composed superficially of keratin-filled cysts and aggregates of basaloid cells in slender cords deeply infiltrating the dermis. The immunohistochemical study revealed a positive pattern for the expression of carcinoembryonic antigen and epithelial membrane antigen, demonstrating follicular and eccrine differentiation, and negative stain for Ber-Ep4, features consistent with microcystic adnexal carcinoma (MAC)¹ (Fig 3).

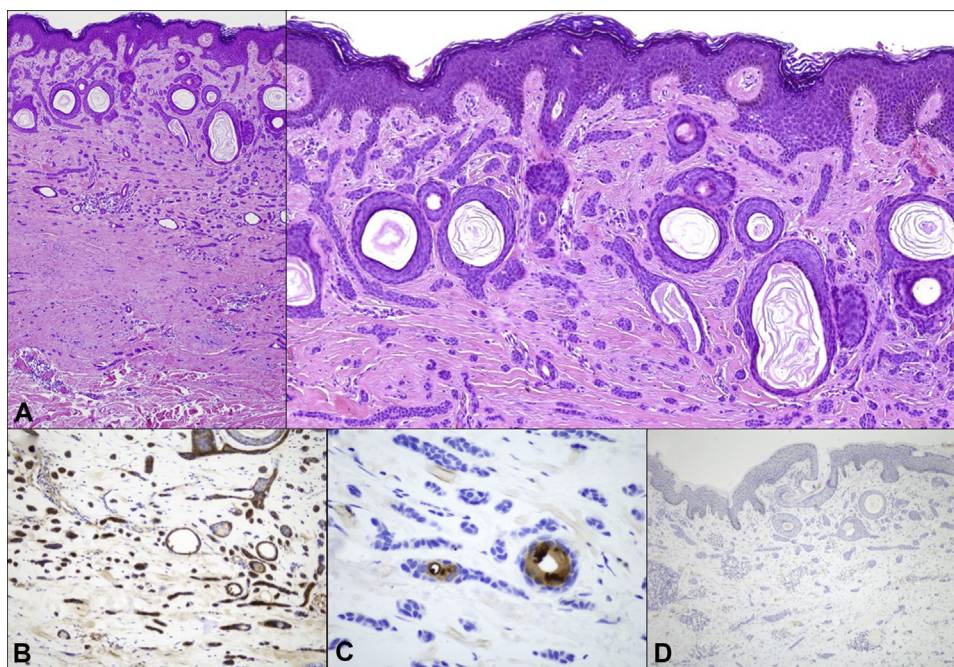


Fig 3. **A**, Microcystic adnexal carcinoma: dermal neoplasm composed superficially of keratin-filled cysts and infiltrative nests of basaloid cells in strands in the underlying reticular dermis. Immunohistochemistry was positive for **(B)** carcinoembryonic antigen and **(C)** epithelial membrane antigen, markers of eccrine and apocrine ducts, favoring microcystic adnexal carcinoma. **D**, Immunohistochemistry negative for BerEp4, a marker of eccrine secretory and follicular germinative cells favoring microcystic adnexal carcinoma. (**A**, Hematoxylin–eosin stain; original magnification: left, $\times 10$; right, $\times 20$.)

KEY MESSAGE

MAC is a rare malignant adnexal tumor with pilar and eccrine sweat gland differentiation.² Clinically, it is characterized by a slow-growing, asymptomatic, firm, papule, plaque, or nodule, affecting middle-aged adults, usually located on the head and neck.^{1,2} MAC is commonly misdiagnosed clinically and histopathologically on account of similar features with other adnexal tumors or basal cell carcinoma.¹ In addition, MAC has a local aggressive growth pattern with the capacity to infiltrate deeply and rarely metastasize. Consequently, inadequate biopsy techniques showing only the superficial component should be avoided.^{1,2} Clinical suspicion of this infrequent tumor supported by dermoscopic findings can aid in early recognition to establish a correct diagnosis and management. Adequate excision with Mohs micrographic surgery to ensure appropriate margin clearance is essential to prevent local recurrences.²

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