Dermatofibroma Over the Face

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A 24-year-old woman presented with an 8-month history of single, progressively growing, asymptomatic, firm lesion over the nose. On examination, there was involvement of the left side of nose in the form of single, well defined, erythematous plaque of size 7 × 6 mm with firm to hard button-like consistency on palpation. Centre of the plaque was slightly depressed [Figure 1a]. Clinical differential diagnosis of nodular basal cell carcinoma (BCC) and early lesion of discoid lupus erythematosus (DLE) were considered. A dermoscopic evaluation revealed a central white scar-like patch surrounded by hyperpigmentation, mild erythema, and few linear telangiectatic vessels, suggestive of dermatofibroma [Figure 1b]. Important dermoscopic features of BCC like linear and arborizing (branch-like) telangiectasia, structure-less or leaf-like areas on the periphery of the lesion, large blue-gray ovoid nests or blotches, multiple blue-gray globules, and specks of brown and gray pigment[1] were not seen. Similarly, dermoscopic features suggesting DLE, i.e., perifollicular whitish halo, follicular keratotic plugs, and scaling[2] were not seen. A biopsy from the centre of the plaque showed an acanthotic epidermis with thinned out rete ridges. There was a grenz zone in the papillary dermis followed by pandermal intersecting bundles of spindle cells with prominent collagen trapping [Figure 1c]. The nucleus of spindle cells was tapered at both ends with indistinct cytoplasm intermingled with histiocytes containing vesicular nuclei [Figure 1d]. A diagnosis of dermatofibroma was considered on clinical, dermoscopic, and histopathological correlation.

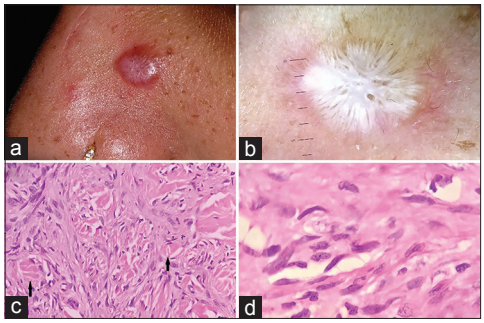

Figure 1: (a) Involvement of left dorsum of nose in the form of well defined, mildly erythematous plaque with slightly depressed centre. (b) Dermoscopy showing a central white scar-like patch with marginal hyperpigmentation, faint erythema and few linear telangiectatic vessels (Heine Delta 20T, polarized, ×10). (c) Involvement of dermis in form of spindle cell proliferation with collagen trapping (Black arrow, H and E, ×400). (d) Spindle cell nucleus tapered at both ends with indistinct cytoplasm intermingled with histiocytes containing vesicular nuclei (H and E, ×1000)

Dermatofibroma is a common benign fibrohistiocytic neoplasm which uncommonly involves the face and neck. It typically presents as a firm to hard, often hyperpigmented, slow-growing, plaque or nodule. The classical histopathological features consist of ill-defined intersecting bundles of spindle cells with collagen trapping. Several dermoscopic patterns of dermatofibroma are described, of which the most common is central white scar-like patch with delicate pigment network at the periphery. Other common patterns include total homogeneous pigmentation and irregular crypts associated with pseudofollicular openings.[3] Surgical excision is the mainstay of therapy. Recently, a study showed that an excisional margin of 3-mm results in complete removal of typical dermatofibromas.[4]

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given

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his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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