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The Clinical Picture

An ulcerated plaque on the hand

FIGURE 1.

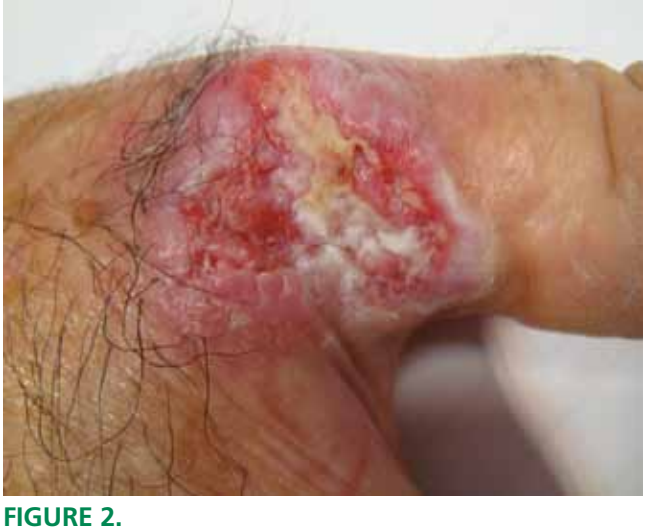

FIGURE 2.

A 73-year-old farmer has a lesion on the dorsum of his right hand that bleeds intermittently. It began 2 years ago as a small itchy papule. It later ulcerated and has gradually increased in size over the past 2 years.

On examination, the lesion is a nontender, ulcerated plaque, 4 cm by 5 cm, with hard and raised edges (FIGURE 1 and FIGURE 2) and with evidence of chronic photodamage. No local adenopathy is noted.

Q: Which is the most likely diagnosis?

- ☐ Blastomycosis
- ☐ Keratoacanthoma
- ☐ Basal cell carcinoma
- ☐ Squamous cell carcinoma
- ☐ Extramammary Paget disease

A: Squamous cell carcinoma is the most likely diagnosis. The lesions may take the form of a patch, plaque, or nodule, sometimes with scaling or an ulcerated center. The borders often are irregular, fleshy, and bleed easily.

Blastomycosis is a rare fungal infection caused by inhaling the spores of the fungus *Blastomyces dermatitidis*. Skin features begin as papules, pustules, or subcutaneous nodules. Over a period of months, lesions heal to form raised wart-like scars, which are often irreversible.

Keratoacanthoma is a benign nonmelanomatous cancer that grows rapidly and remits spontaneously. This diagnosis is unlikely in our patient, whose lesion evolved over 2 years.

Basal cell carcinoma has a waxy, translucent, or pearly appearance, without a keratotic component. Telangiectasias are common. Unlike squamous cell carcinomas, the edges of basal cell lesions are clear rather than fleshy.

Extramammary Paget disease usually manifests as intense pruritus in affected areas, which appear as chronic intertrigo or nonre-

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solving eczema. The dorsum of the hand is a very rare location for this disease. Given our patient's presentation, extrammary Paget disease is an unlikely diagnosis.

CHRONIC SUN EXPOSURE IS A KEY RISK FACTOR

Our patient has worked outdoors for many years, and chronic sun exposure is a key risk factor for squamous cell carcinoma.[1]

Squamous cell carcinoma is a nonmelanomatous skin cancer arising from the more superficial layers of keratinocytes. Unlike basal cell carcinoma, it can metastasize,[2] so the diagnosis must be made as soon as possible.

The key to diagnosis is a high degree of suspicion. Patients usually present with chronic sun-damaged skin with lesions as actinic keratoses or keratin horns. Squamous cell carcinoma appears as a thick, adherent scale that does not heal and may intermittently bleed. Because it spreads into the dermis, it can appear like an ulcer, with hard, raised edges, as in our patient.

TREATMENT AND PREVENTION

The standard effective treatment is complete surgical excision.[1] Nonsurgical treatments include curettage plus cautery, cryosurgery, radiotherapy, photodynamic therapy, and imiquimod (Aldara) 5% cream. Minimizing sun exposure and regular checkups are important preventive measures.

Our patient underwent total surgical excision of the lesion. Due to the size of the lesion, a skin graft was required and was obtained from the abdomen. No relapse was observed after 1 year of follow-up.

REFERENCES

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