

Seborrhoeic wart

Synonyms: seborrhoeic keratosis, basal cell papilloma

Seborrhoeic warts (also known as seborrhoeic keratoses) are common benign, hyperkeratotic skin lesions associated with ageing.

Aetiology^[1]

The cause is not fully understood. They appear to be a degenerative condition. Sunlight appears to play a role in causation, given the typical distribution of seborrhoeic warts. They have been known to follow sunburn.

Some cases of multiple seborrhoeic warts are inherited in an autosomal dominant pattern^[2]. Oncogenic mutations are involved in pathogenesis and a broad spectrum of somatic mutations in the FGFR3, PIK3CA, RAS, AKT1 and EGFR genes has been noted^[3].

Epidemiology^[1] [4]

- Presence and frequency increases with age: almost all elderly patients have some. It has been estimated that over 90% of adults aged 60 or more have at least one seborrhoeic wart.
- They usually present from the fourth decade onwards.
- No sex difference exists.
- Seborrhoeic warts are less common in dark-skinned races but can occur in anyone.
- The trunk and face are the sites most commonly affected.
- It is common to have more than one lesion and there may be many lesions.

Presentation

Typical clinical appearance

- Flat-topped or warty-looking lesions that appear to be 'stuck on' to the skin.
- Usually pigmented, sometimes deeply and may even be black. Others can be paler in colour.
- There is usually a well-circumscribed border.
- Size ranges from 1 mm to several cm.
- The surface is usually pitted and irregular with visible keratin dots giving a granular and rough appearance.
- Initially, lesions are velvety and soft in texture, before developing a warty surface and becoming uneven, with multiple plugged follicles.
- The surface may become covered by adherent greasy scale.
- Multiple lesions may align along skin folds.
- They are usually asymptomatic but may become irritated, itchy or inflamed spontaneously or after minor trauma.



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Dermoscopic features^[4] ^[5]

- Thickened epidermis with multiple milia-like cysts and comedo-like openings.
- Gyri and sulci (looking like the surface of the brain).
- Fingerprint-like structures.
- Blood vessels are fine, regular and hairpin in shape and surrounded by a milky halo.
- 'Moth-eaten' borders in the thinner lesions.

Variants

Less common variants of seborrhoeic warts include:

- **Stucco keratoses** – multiple skin-coloured or white, dry, scaly lesions often seen on the extremities (dorsa of hands, forearms, ankles and feet) [6].
- **Dermatosis papulosa nigra** – multiple small, brown or black pedunculated lesions seen on the face of dark-skinned individuals. Often have an earlier onset than typical seborrhoeic warts [7].
- **Solar lentigo** – well-circumscribed, flat pigmented patches which occur in sun-exposed areas [8].
- **Melanoacanthoma** – very deeply pigmented seborrhoeic warts [9].

Differential diagnosis [10]

- Malignant melanoma.
- Verruca vulgaris.
- Condyloma acuminatum.
- Fibroepithelial polyp.
- Epidermal naevus.
- Melanocytic naevus.
- Pigmented basal cell carcinoma.
- Squamous cell carcinoma.

Associated diseases

Although skin malignancy is thought to occur by chance in patients with seborrhoeic warts, studies report the occasional association with Bowen's disease and squamous epithelial dysplasia [11]. This occurs more frequently in regions with high solar ultraviolet levels [12]. Rarely, a sudden onset or increase in the number of seborrhoeic warts can herald an underlying malignancy (usually adenocarcinoma of the stomach but also colon, breast and lung) [13]. It can be associated with acanthosis nigricans. This sudden increase is known as the Leser-Trélat sign [4]. The same phenomenon without internal malignancy is known as a pseudo-Leser-Trélat sign [14].

Management^[4]

- Reassurance: most often, no treatment is required.
- Remove where there is cosmetic dislike, repeated irritation or chafing from clothes, or diagnostic uncertainty.
- Removal by cryotherapy (this may require repeat treatments), curettage and cautery or shave excision are effective and produce a better result than excision and suture, although a pale white scar can be left.
- Dermoscopy may be used by appropriately trained GPs to assist in diagnosis^[15].

When to refer

Usually, they can be managed in primary care. However, patients with lesions requiring removal from difficult areas should be referred. Lesions that are suspicious of melanoma (either with the naked eye or by dermoscopy) should be sent as a cancer network two-week referral to a dermatologist^[15].

Complications

- Repeated irritation and inflammation where lesions catch on clothing.
- Aesthetic dislike.
- Concerns regarding malignancy:
 - It is harder to notice a malignant melanoma arise amongst multiple seborrhoeic warts.
 - Rarely, melanoma in situ can arise within a seborrhoeic wart, although this is rare^[16].

Prognosis

Although seborrhoeic warts are benign, they do not spontaneously resolve and they become larger and thicker with time.

Further reading

- [Noiles K, Vender R](#); Are all seborrheic keratoses benign? Review of the typical lesion and its variants. J Cutan Med Surg. 2008 Sep-Oct;12(5):203-10.

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