

Giant Lumbar Polypoid Tumor with Bullae on its Surface

Dear Editor,

Acrochordons are common benign neoplasms found in everyday practice. We present a rare case of a giant and single acrochordon on the lumbar region with signs of ischemia. The correlation of clinical, dermatoscopic, and histopathological analyses may help the clinician differentiate this entity from other benign and malignant dermatoses.

A 33-year-old man presented to the outpatient clinic complaining of a lumbar mass that had been growing for two years. The lesion was asymptomatic except for recent discomfort when lying in the supine decubitus position. On examination there was a single, erythematous, non-tender pedunculated lesion, 5.1 cm × 4 cm × 3.2 cm in size, with flaccid bullae on its surface and firm consistency (Figure 1, a-b). Dermoscopy showed regularly arranged dotted vessels in a violaceous background and bullae filled with serous

fluid (Figure 1, c-d). His personal and family medical history were unremarkable. Shave excision was performed and the sample was sent for histopathologic analysis. Histopathology revealed a normal epidermis surrounding a core of loose collagen fibers. Papillary dermis showed a mixed inflammatory cell infiltrate, congested capillaries, and extravasated erythrocytes. Scattered clusters of adipocytes were found in the deep dermis (Figure 2). The diagnosis of a giant ischemic acrochordon was established.

Acrochordons, also commonly known as skin tags, are benign pedunculated neoplasms frequently found on the neck, axillae, or groin. They represent fibroepithelial polyps that originate from ectoderm and mesoderm tissue (1). They can be pigmented or

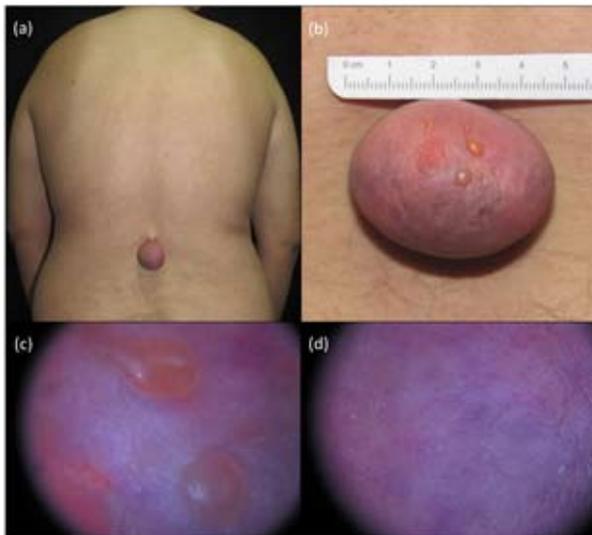


Figure 1. (a) Single, erythematous, pedunculated lesion in the lumbar region. (b) Neoplasm with flaccid bullae on its surface and firm consistency. (c) Dermoscopy revealed bullae filled with serous fluid. (d) Regularly arranged dotted vessels in a violaceous background.

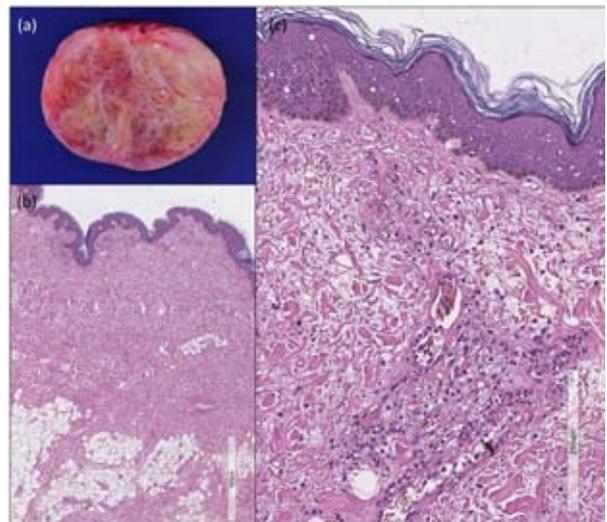


Figure 2. (a) Gross pathology examination of the resected specimen. (b) Histopathology revealed a normal epidermis surrounding a core of loose collagen fibers and deep dermis clusters of adipocytes (Hematoxylin and eosin stain, ×2.5 magnification). (c) Congested and dilated capillaries with a perivascular mixed inflammatory cell infiltrate in the papillary dermis (Hematoxylin and eosin stain, ×11.2 magnification).

skin colored and usually range between 2 to 5 mm in size. Skin tags can affect nearly 46% of the general population (2). Giant and solitary acrochordons are an uncommon clinical variant (2).

Differential diagnosis of this pathology may be challenging in the particular clinical context of this patient. Benign neoplasms such as dermatofibroma, neurofibroma, and epidermal inclusion cysts can be clinically similar to giant skin tags (1,2). Histopathological analyses of acrochordons usually show papillomatosis, irregular acanthosis, loose collagen fibers, and dilated capillaries (2). A fibrolipomatous variant of acrochordon may reveal adipose tissue lobules between septa of collagen on pathological examination (1). Local ischemia due to twisting of the stalk may induce the formation of intradermal or subepidermal blisters in these tumors. Histopathologic characteristics found in ischemic acrochordons are neutrophil infiltration, congested capillaries, and extravasated erythrocytes (3). Fibroepithelioma of Pinkus (FeP) is a rare variant of basal cell carcinoma that may clinically mimic benign polypoid tumors and has a certain predilection for the lumbosacral area. Dermoscopic characteristics of fibroepithelioma of Pinkus that may aid the clinician in this diagnosis are fine arborizing vessels, either alone or associated with dotted vessels, and white streaks (4).

Cosmetically adequate treatment of a giant acrochordon can be performed by shave excision and electrodesiccation of its pedicle. Choudhary et al. reported good results with this technique on a giant acrochordon on the thigh (5).

References:

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