8. Zak FC, Solomon A, Fellner MJ. Viscerocutaneous angiomatosis with dysproteinemic phagocytosis: its relation to Kaposi's sarcoma and lymphoproliferative disorders. J Pathol Bacteriol 1966;92:594-9.
9. Pembroke AC, Grice K, Levantine AV, Warin AP. Eruptive angiomata in malignant disease. Clin Exp Dermatol 1978;3:147-56.
10. Torres JE, Sanchez JL. Disseminated pyogenic granuloma developing after an exfoliative dermatitis. J Am Acad Dermatol 1995;32:280-2.
11. Harman RRM. Primary biliary cirrhosis with unusual skin changes. Br J Dermatol 1977;97:62-4.
12. Rusin LJ, Harrell ER. Arteriovenous fistula: cutaneous manifestations. Arch Dermatol 1976;112:1135-7.

Dermatoscopic characteristics of acrochordon-like basal cell carcinomas in Gorlin-Goltz syndrome

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Background: Gorlin-Goltz syndrome (GGS) is an autosomal-dominant disease characterized by the early onset of multiple basal cell carcinomas (BCCs), among other findings. Clinically, the BCCs may appear as soft pedunculated neoplasms that can be mistaken for true acrochordons.

Objective: We sought to describe the dermatoscopic characteristics of small acrochordon-like or polypoid BCCs in a child with GGS, and to perform histopathologic correlation.

Methods: Acrochordon-like growths from a child with GGS were studied. Clinical records and digital dermatoscopic images were collected, and excision and histopathologic examination of the most representative lesions were performed.

Results: Some acrochordon-like lesions showed specific dermatoscopic criteria for BCC, including multiple blue-gray globules and arborizing telangiectasia. Other polypoid lesions, especially the smaller ones, exhibited characteristics that suggested BCC, such as isolated blue-gray globules, small blue-gray ovoid nests, and fine elongated telangiectases.

Limitations: Conclusions are limited by the small sample size.

Conclusion: Dermatoscopy may be a useful diagnostic tool to analyze acrochordon-like lesions in children and to facilitate early diagnosis and treatment of BCCs in patients with GGS. (J Am Acad Dermatol 2009;60:857-61.)

The nevoid basal cell carcinoma (BCC) syndrome or Gorlin-Goltz syndrome (GGS)[1] is an autosomal-dominant disease caused by mutations in the PTCH1 gene, a tumor suppressor gene.[2] It is characterized by early onset of multiple BCCs, odontogenic keratocysts, palmar and plantar pits, skeletal anomalies, and ectopic calcifications. Most cases present in the first and the second decades of life.[3-5]

BCCs in patients with GGS usually appear as 1- to 10-mm hyperpigmented or skin-colored, dome-shaped papules, soft nodules, or flat plaques.[3,4] Solid

Abbreviations used:

BCC: basal cell carcinoma
GGS: Gorlin-Goltz syndrome
PBCC: polypoid basal cell carcinoma

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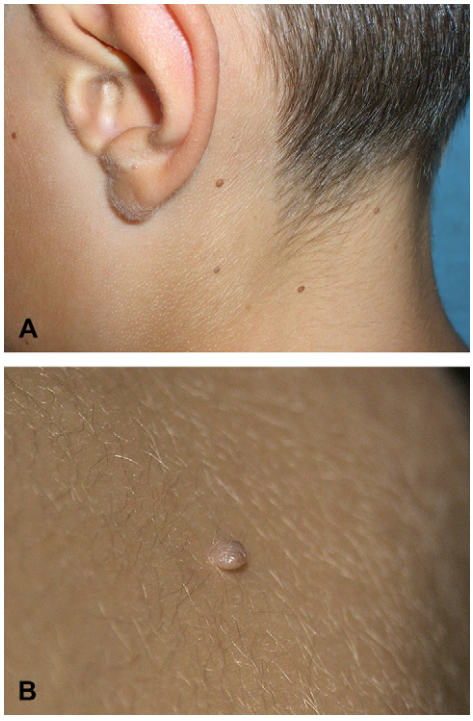

Fig 1. **A**, Soft, pedunculated papules on neck. **B**, Clinical detail of one acrochordon-like lesion.

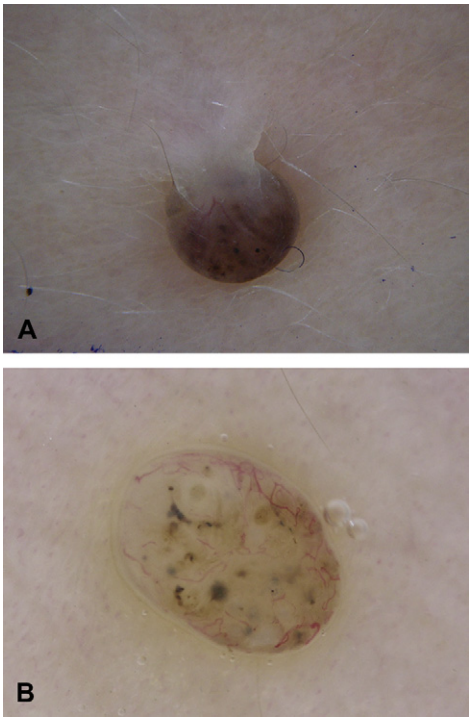

Fig 2. Dermatoscopic images of several acrochordon-like basal cell carcinomas. **A**, Smaller lesions only show some blue-gray globules. **B**, Larger lesions show small blue-gray ovoid nests and arborizing, sharply focused telangiectasia on surface of tumors. (**A** and **B**, Original magnifications: ×10.)

and superficial types of BCC are the most common[4] and infundibulocystic BCC is frequent.[6] BCCs in patients with GGS may be mistaken for melanocytic nevi, hemangiomas, molluscum contagiosum, and acrochordons (skin tags).[7] There are a few reported cases of polypoid BCC (PBCC) or acrochordon-like BCC in GGS.[8-10] Clinically, the polypoid shape and soft texture of PBCCs or acrochordon-like BCCs make them difficult to distinguish from true acrochordons.

We describe a child with GGS in whom dermatoscopy helped to identify multiple small BCCs that clinically resembled true acrochordons.

CASE REPORT

A 7-year-old boy, whose mother was recently given the diagnosis of GGS, was examined and found to have more than 100 papules on his face, neck, and upper aspect of chest and back; additional lesions were detected on the lower aspect of his trunk and in the popliteal fossae. A radiographic skeletal survey revealed scoliosis, shortened fourth metacarpals, and an odontogenic keratocyst of the jaw. There was no palmoplantar pitting.

Papules on the neck, upper aspect of chest and back, lower aspect of trunk, and popliteal fossae were soft and pedunculated with variable hyperpigmentation, ranging from 1 to 4 mm (most were 2 mm) in diameter (Fig 1). Other lesions, mainly located on the face, were pearly, minimally pedunculated papules measuring less than 2 mm. The pedunculated lesions resembled skin tags or acrochordons. Dermatoscopic examination did not reveal the characteristic criteria for melanocytic lesions. BCCs were suggested by the presence of multiple or isolated gray-blue globules and/or telangiectases of different caliber and number of branches, depending on the size of the lesion. Usually, acrochordon-like lesions less than 3 mm in diameter only showed gray-blue globules (Fig 2, *A*); larger lesions also showed small blue-gray ovoid nests and/or telangiectases spreading over the surface of the tumor (Fig 2, *B*). Other specific criteria for the diagnosis of BCC, such as ulceration, maple leaflike areas, or spoke-wheel areas were not detected.

Eleven representative acrochordon-like lesions on the neck (1), chest (1), upper aspect of back (5), lower aspect of trunk (2), and popliteal fossa (2) were removed by shave excision and cautery. The clinical and dermatoscopic characteristics of these lesions are shown in Table I. Most (10) were histologically confirmed as infundibulocystic BCC. The remaining lesion was diagnosed as fibroepithelioma of Pinkus. The infundibulocystic BCCs showed a well-demarcated polypoid configuration with buds and cords of