

Common skin and soft tissue tumors

Dr. Khalid Al-Zahrani

Skin lesions

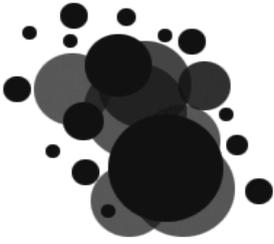
- Pigmented vs. non-pigmented.
- Benign vs. malignant.

Skin-benign-non-pigmented

- **Epidermal:**
 - ✓ SK. Serrokeratosis (can be single or multiple) patch stuck on skin
- **Dermal:** (from the hair follicle, sebaceous gland)
 - ✓ Tricoepitheloma. (in the face, can be single or multiple)
 - ✓ Sebaceous hyperplasia. (in glands, e.g. Rhinofoma → gives a huge nose mainly from thick skin, foul smelling, presents in Caucasian and > 60 yrs old)
 - ✓ Apocrine vs. eccrine hydrocystoma. (a kind of a cyst arising from the sweat glands, grows with sweating, that's why it increases in the summer)
 - ✓ Eccrine → thermal regulation, distributed throughout body, apocrine → in axillary region, function at puberty

Skin-benign-pigmented

- **melanocyte based:**
 - ✓ Epidermal:
 - Café-au-lait.
 - ✓ Dermal:
 - Mongolian spot. (greenish or bluish discoloration in the back and buttock due to decreased migration of melanocytes, appears in neonates then disappears)
 - Blue nevus.



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- **Nevus cell based:**
 - ✓ Nevus cell is actually a melanocyte w/out dendrocytes but rounded with a large nuclei
 - ✓ Congenital. (Giant hairy nevus where the carrier risk for melanoma is 5-10%)
 - ✓ Acquired:
 - Junctional-mixed-dermal (7abba al 5al)

Skin-benign-pigmented

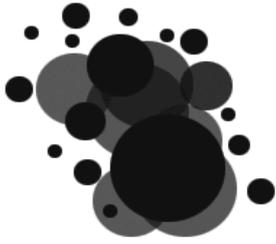


Congenital hairy nevus

- has a malignant potential
- difficult to excise if too large like in this case

Nevus





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Skin-premalignant

(Pre-malignant lesions are benign but can develop into malignant)



Cutaneous horn

- main feature the length > the width (the base)
- May transform to squamous cell ca, in this case needs excision.



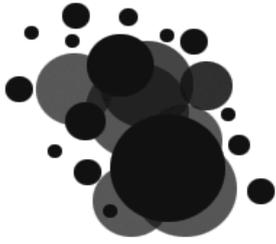
Leucoplakia

- Present in buccal mucosa and commisure
- Due to irritation as a result of (sharp teeth, smoking, alcohol, poor hygiene, spicy food)
- May transform to squamous cell ca.
- Rx: biopsy (if benign only stop the irritating factor)



Nevus capitis of Jadson

- In pediatric pts. (grows w/ age)
- May transform to BASAL cell ca.
- Excised before puberty (12yrs old)



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Porokeratosis

- Will transform to Basal cell ca. in 30% of cases
- Brownish patches, seen in elderly,

Skin-malignant



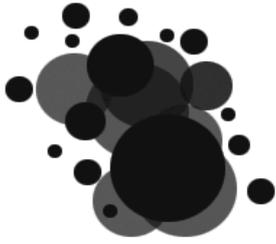
Squamous Cell Ca.

- High risk of malignancy → examine LNs
- Common in :
 - ✓ Fairly skin people
 - ✓ ultraviolet light C (C is more carcinogenic than B)
 - ✓ Immunocompromised pts. (specially after transplant)
- It can metastasize to??
- Rapid growing tumor



Basal Cell Ca.

- The most common malignant skin lesion (common site is the nose)
- It doesn't metastasize & slowly growing



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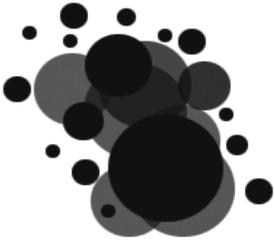
- The most common type is nodular BCCa
- It may ulcerate causing Rodent ulcer
- To confirm Dx, we need biopsy which can either be incisional (whole tumor, if it was small) or excisional (take a small piece)
- Rx: surgical excision + safe margin

☒ N.B: 1st treatment modality for both BCC & SCC is surgery, but it's the margin that differs. In SCC with wide margin(1 cm), but in BCC with narrow margin(3-4 mm).

Melanoma



- The most serious skin malignancy → can metastasize anywhere !
- Most melanomas arise de novo without pre-existing lesion.
- **Clinical types:**
 - ✓ *Superficial spreading.....67%*
 - ✓ *Nodular.....10% (worst than superficial)*
 - ✓ *Lentigo maligna melanoma*



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✓ *Acral lentiginous melanoma.* (mostly in blacks)

• The most important in this tumor is the **depth of the lesion:**

✓ Clark's classification (according to level of tumor)

✓ Breslow's classification (more accurate and the most imp. classification which based on thickness of skin)

• Rx: surgical removal with margin –if the depth of the lesion is 4mm, the margin will be 2-3cm.

• The deeper it is the wider the margin should be.

• Must be excised early because the prognosis is very poor

• **Clark's level:**

✓ *I. in situ.....100% (inbounded by basement membrane, doesn't go further)*

✓ *II. Papillary dermis.....99%*

✓ *III. Papillary/reticular..95%*

✓ *IV. Reticular dermis.....75%.*

✓ *V. subcutaneous.....30%.*

• **Breslow's:**

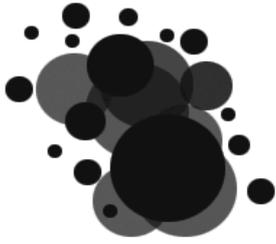
✓ *I. <0.75mm.....100%*

✓ *II. 0.76 – 1.5mm.....90%*

✓ *III. 1.51- 3.99.....88%*

✓ *IV. >4mm40%*

Examine LN, screen for metastasis!



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Lipomas:

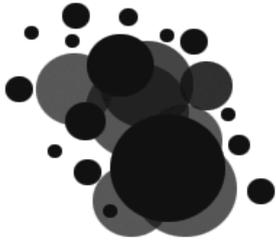
- The most common type is subcutaneous lipoma.
- Can be diffused.

Table 1 Classification of Benign Fatty Tumours of the Upper Limb.

Cell Origin	Name of the Tumour	Tumour Sub-types
Immature fat cell (lipoblast)	Lipoblastoma	Circumscribed, diffuse
Mature brown fat cell	Hibernoma	—
Mature white fat cell (lipocyte)	(a) Dermal lipoma	—
	(b) Subcutaneous lipoma	Single vs. multiple, syndromal vs. non-syndromal, encapsulated vs. diffuse.
	(c) Sub-fascial lipoma	Sub-fascial lipomas of the digits, deep palmar lipomas of the hand, sub-fascial lipomas of the arm and forearm.
	(d) Muscle-related lipoma	Inter- and intra-muscular.
	(e) Bone-related lipoma	Intraosseous, parosteal.
	(f) Synovium-related lipoma	Tendon sheath lipoma, joint synovium lipoma.
	(g) Nerve-related lipoma	Encapsulated intra-neural lipoma, diffuse lipofibromatous hamartoma of nerve.

Vascular lesions

- Tumors: they are either tumors or vascular mal formations
 - ✓ Hemangioma.
- Vascular malformation.
 - ✓ Low flow:
 - Capillary, lymphatic, venous or mixed.
 - ✓ High flow:
 - Arterial.
 - Arteriovenous.



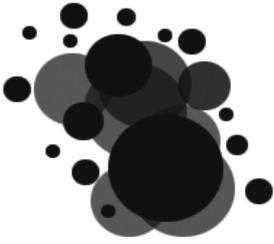
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	Hemangioma	Vascular malformation
Nature	A tumor, increase mast cells, proliferation of....	Only a collection of abnormal blood vessels(it's not a tumor)
Clinically	Congenital, rapid growing appears in childhood, not at birth. the most common benign tumor in children	Present at birth even if not evident. Grows slowly & proportionate to growth of pt.
Radiology		Venus: increase bone growth (hypertrophy) Arterial: obstructive growth (destruction of bone)
Rx	Wait and it will disappear (6-7yrs) but if it affects function e.g. Hemangioma eye lid or air way hemangioma Rx. will be medical (steroids) or surgical.	Unless there symptom don't do anything. If there are symptoms or affecting major function: surgical removal

Vascular-benign





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How to differentiate?

- Definition.
- Clinical.
- histology.
- Radiology.
- Skeletal.

Neurofibromatosis I

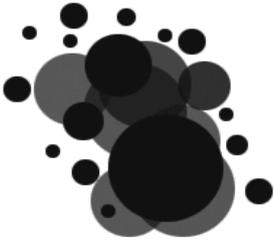
- Café-au-lait >6.
- 2 or more neurofibromas or one plexiform.
- Freckling.
- Optic gliomas.
- Lisch nodules.
- Osseous lesion.
- 1st degree relative.

We need at least 2 of these to diagnose NF1

Neurofibromatosis II

- Acoustic neuroma





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Ganglion cell tumors:

- The most common tumor in hand
- Occur usually inside rist joint
- It is a collection of fluid between rist bones
- Rx:
 - ✓ aspiration or
 - ✓ aspiration+ steroids
 - ✓ But if it is big or had recur causing symptoms- surgical removal+ ligation of the duct.

Others:

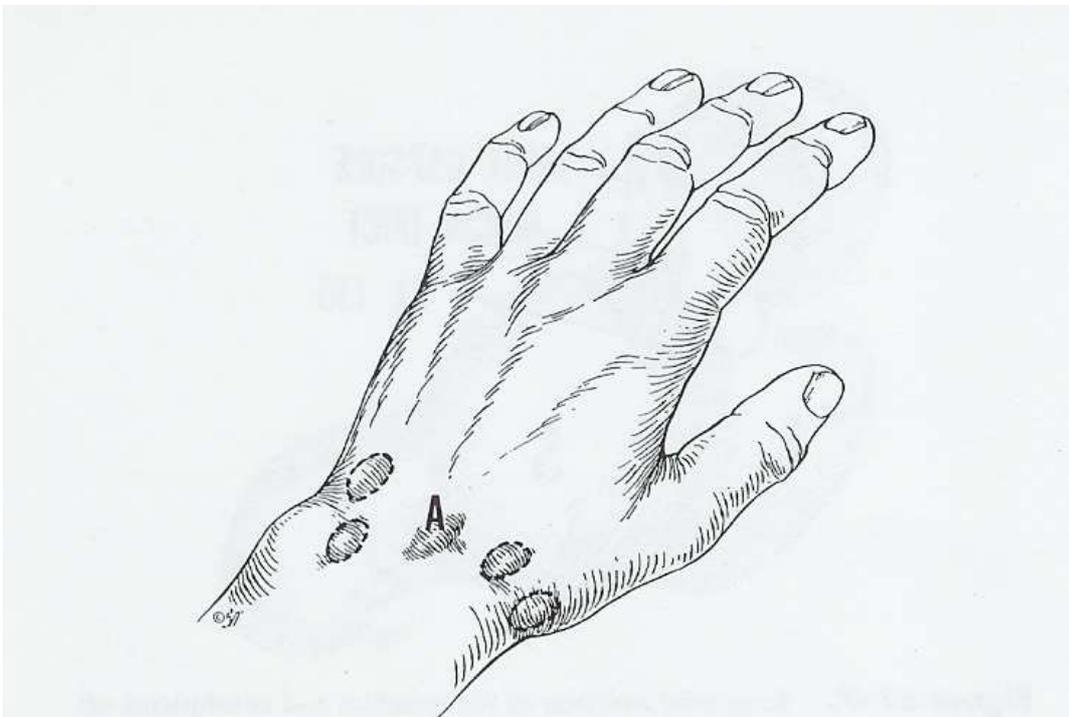
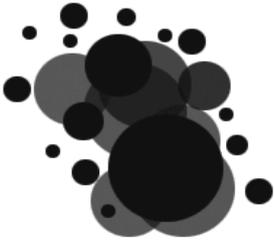


Figure 67-1. A few of the many possible locations of dorsal wrist ganglions. (A) The most common site, directly over the scapholunate ligament. The others (*dotted circles*) are connected to the scapholunate ligament through an elongated pedicle.



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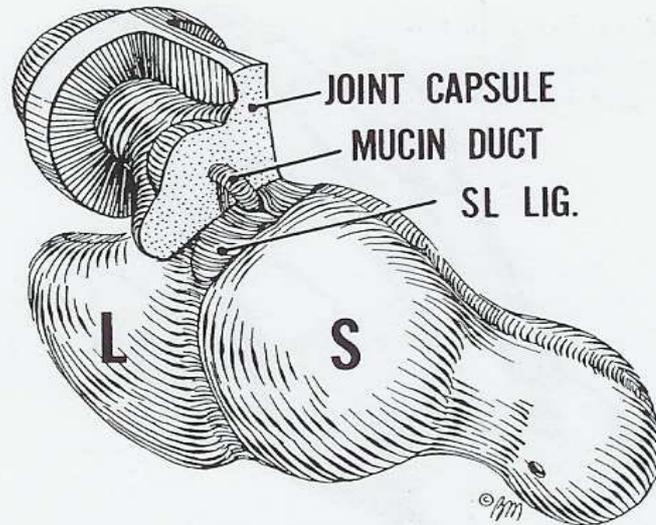
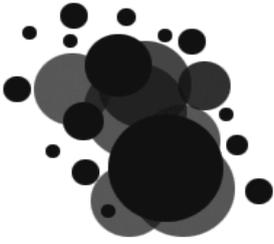


Figure 67-7. Tangential excision of the ganglion and attachments off the fibers of the scapholunate (SL) ligament. A minute mucin duct piercing the fibers of the scapholunate ligament is invariably cut during this dissection.

Pictures:

Skin-malignant

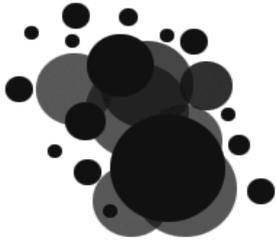




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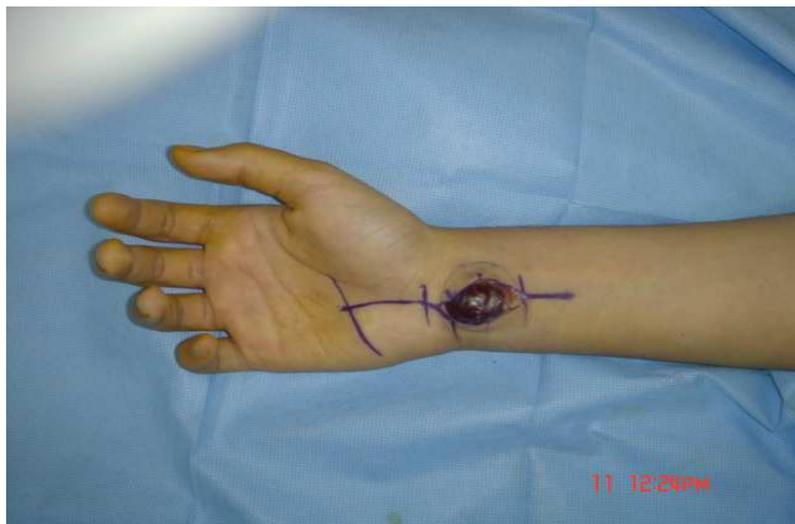
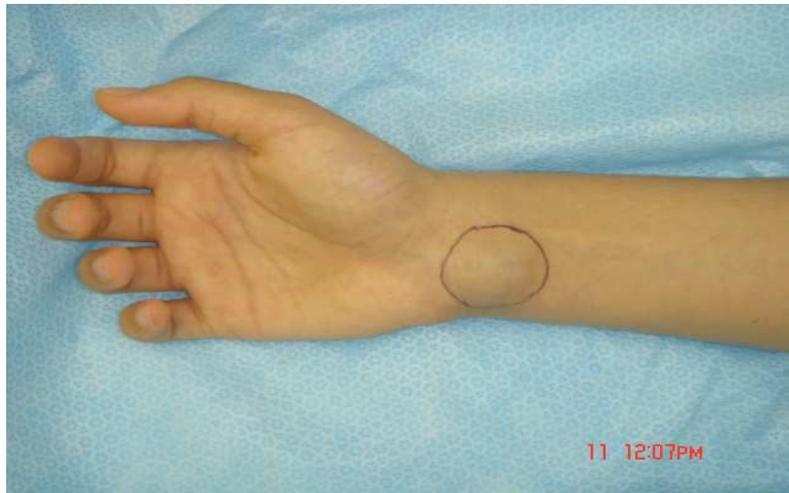


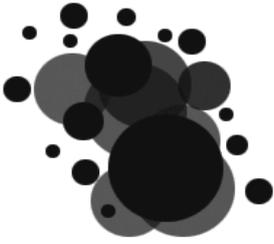


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Vascular-benign



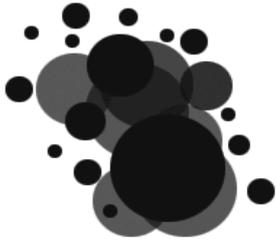


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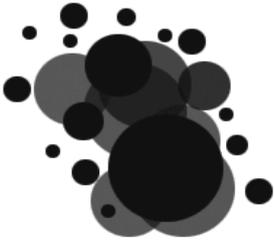
Nervous tissue



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