All Ears: Can You Identify These Lesions?

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An 80-year-old man has had an asymptomatic, flesh-colored swelling on his right ear for 4 to 5 months. In the center is a 1-mm white scab pointing downward from the helix. At times, the patient shaves a white spicule that grows in this crusted area. He sleeps on his right side and does not use a cell phone.

**Case 1:**
An 80-year-old man has had an asymptomatic, flesh-colored swelling on his right ear for 4 to 5 months. In the center is a 1-mm white scab pointing downward from the helix. At times, the patient shaves a white spicule that grows in this crusted area. He sleeps on his right side and does not use a cell phone.
What type of lesion is this, and how is it best removed?
(Answer on page 1353.)

**Case 2:**
This tan, 7 3 5-mm, papillary lesion with a broad, slightly elevated, eccentric base has been present for several months on the right anterior helix of a 24-year-old man. It is asymptomatic.
What are you looking at here?
(Answer on page 1353.)

**Case 3:**
A 35-year-old woman is concerned about a 1-cm swelling that suddenly appeared in the superior crus of the right antihelix. The lesion is fluctuant and asymptomatic; no tenderness or warmth is felt on palpation. She denies trauma to the area.
How would you proceed?
(Answer on page 1354.)

**Case 4:**
This asymptomatic, 0.5-cm, red berry-like lesion in the concha of a 39-year-old man's left ear has been gradually enlarging for 3 months.
Is this lesion cause for alarm?
(Answer on page 1354.)

**Case 5:**
For several months, a 67-year-old man has had an asymptomatic, 0.5-cm, light tan lesion with brown specks on his left ear that is slightly raised and finely roughened (A).
A 69-year-old woman presents with a raised, elongated, light tan lesion on the anterior aspect of the superior helix of about 1 month's duration (B). It is also asymptomatic.
Can you identify these lesions?
(Answer on page 1356.)

**Case 6:**
An 84-year-old man presents for evaluation of a raised, pink lesion with a tiny scab on the anterior ridge of the left lower helix. This asymptomatic, 0.5-cm lesion has been present for 2 months.
What approach would you take?
(Answer on page 1356.)

**Case 1:** The entire lesion was removed by elliptical excision under local anesthesia and sent for histopathologic examination. The diagnosis was **chondrodermatitis nodularis helicis**—a benign, usually solitary, chronically crusted nodule that develops most commonly on the superior helix of the right ear in men older than 50 years. In women, the lesion occurs less frequently and more commonly on the antihelix. The lesions can be painful.
The suspected cause of chondrodermatitis nodularis helicis is localized degeneration of dermal collagen with its subsequent partial extrusion through a central ulceration. Long-term cell phone use is associated with the development of this lesion at the point of pressure on the ear. Other possible causative factors include minor trauma, pressure during sleep, poor vascularity, and solar damage.
Systemic sclerosis and dermatomyositis are rare associations. Perforation of the infundibular portion of a hair follicle with extrusion of its contents into the dermis is another suggested cause. Treatment options include excision, cryotherapy or curettage, and cautery. A recurrence rate of up to 20% has been reported. This patient's ear healed without complication. The lesion has not recurred.

**Case 2:** The lesion was removed by shave excision in the office under local anesthesia, and its base was desiccated and curetted. Histopathologic examination confirmed the clinical diagnosis of *verruca vulgaris.*

Common warts may occur on any skin surface--although they most frequently occur on the hand and fingers--and are usually few in number. These benign lesions are caused by human papillomaviruses (HPVs). More than 100 types of HPVs exist, with new types discovered each year. The clinical manifestations (sites) of warts vary depending on the HPV type. The common wart is associated with HPV types 2, 4, and 29.

Treatment of warts depends on their size and location. Options include cryotherapy, electrodesiccation and curettage, topical keratolytic agents, immunomodulator drugs, vitamin A, laser, chemotherapy, formalin, intralesional bleomycin, and duct tape occlusion. Suggestive therapy may work for some patients.

After this patient's lesion was removed, antibiotic ointment was applied. The ear healed with excellent cosmetic results.

**Case 3:** Aspiration of the lesion with a large bore needle yielded 1.5 mL of clear serous fluid. It was felt the lesion represented an *auricular seroma,* which probably resulted from the shearing force of her head against her pillow during sleep.

Generally, seromas tend to develop in incisions after surgery. Auricular seromas are rare, but they should be included in the differential diagnosis of an asymptomatic, noninflammatory swelling of the ear. The lesions may drain spontaneously. In this patient, simple aspiration was curative.

**Case 4:** The lesion is a *pyogenic granuloma.* This benign hemangioma of mucous membranes and skin occurs most commonly on the gingiva, lips, fingers, and face and less commonly on the trunk, arms, legs, and conjunctiva. Most are polypoid or pedunculated; they are less commonly sessile. The base is often surrounded by a ring of fine scale.

Pyogenic granulomas evolve rapidly over weeks, frequently become ulcerated, and bleed easily. The lesions can develop at any age, in both sexes, and in a nevus flammeus or spider angioma. Occasionally, more than 1 lesion is present. Most pyogenic granulomas occur spontaneously; however, they may follow trauma, retinoid therapy, injury (such as an insect bite, burn, or scald), or cryotherapy.

Spontaneous resolution of a pyogenic granuloma is uncommon, except in the case of epulis gravidarum (pyogenic granuloma of the gingiva that develops during pregnancy). Treatment includes excision or desiccation and thorough curettage. If any tissue remains, recurrence is likely. In this patient, the lesion was removed via shave excision, treated with light curettage, and cauterized with ferric subsulfate solution. Topical mupirocin ointment was applied until the ear healed.

**Case 5:** These lesions are *seborrheic keratoses.*

Seborrheic keratosis is one of the most common benign skin tumors; the cause is unknown. These neoplasms present in numerous forms; they may be flat or, as shown here, raised with smooth or cracked surfaces. Raised lesions are superficial and can be easily treated by electrodesiccation and curettage, with or without shave removal. Some seborrheic keratoses may mimic malignant melanoma. If there is any doubt about the diagnosis, a biopsy is mandatory.

The lesion in photo A--although unique in that it occurred on the cymba concha of the external ear--was diagnosed based on its clinical appearance. The lesion was lightly desiccated and treated with curettage under local anesthesia and topical antibiotic ointment. The ear healed without complication.

The lesion in photo B was removed via elliptical excision under local anesthesia. Histopathologic examination of the excised lesion revealed mild chronic inflammation and mild solar elastosis, which confirmed the diagnosis. The ear healed with excellent cosmetic results.

**Case 6:** The lesion was removed by elliptical excision. Histopathologic examination of an excised specimen revealed *actinic keratosis* and marked solar elastosis of the dermis with minimal atypia. Actinic keratosis is confined to the epidermis. It typically occurs on sun-exposed areas; the incidence increases with age. An untreated lesion may involve deeper skin layers and develop into full-fledged squamous cell carcinoma. To assuage fears about cancer, stress to patients that actinic keratosis is premalignant, but advise them to monitor their skin for possible recurrence.
Biopsy--incisional or excisional, depending on the size of the lesion--is necessary for diagnosis. Treatment modalities include surgical removal, cryotherapy, and topical 5-fluorouracil and imiquimod creams or diclofenac gel. This patient's ear healed without complication. *


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