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Halo Seborrheic Keratosis in a Patient of Color With Vitiligo

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ABSTRACT

A 73-year-old woman with Fitzpatrick skin type V presented with a long-standing brownish-black, three-tone macule on the right anterior thigh that developed a sharply demarcated depigmented halo. She also exhibited depigmented patches on the buttocks, hands, and feet consistent with vitiligo. Horizontal excision with histopathology confirmed seborrheic keratosis (SK) without atypia. This case highlights that the halo phenomenon can occur in non-melanocytic lesions, including SK,[1] a presentation that may mimic melanoma and complicate diagnosis in richly pigmented skin.[2,3] We review halo SK, discuss dermoscopic–pathologic features that distinguish it from melanoma and adult-onset halo nevus, and summarize evidence-based therapies for coexisting vitiligo, including topical ruxolitinib 1.5% cream and narrowband UVB (NB-UVB).[4,5]

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INTRODUCTION

Practice Points

- Depigmented halos are not restricted to melanocytic lesions; SK can rarely display a halo and may clinically resemble melanoma.[1,2]
- Dermoscopy of seborrheic keratosis is characterized by features such as milia-like cysts, comedo-like openings, a cerebriform sulcus–gyrus pattern, moth-eaten borders with irregular peripheral indentations, and sharp demarcation.[2] However, melanoma clues include blue-black/blue-white structures and an atypical network. Recognition of these patterns guides biopsy decisions.[2,6]
- In skin of color, overlapping dermoscopic findings (eg, clonal SK vs pigmented basal cell carcinoma) create diagnostic pitfalls, underscoring the need for biopsy when uncertain.[3]
- For vitiligo, phase 3 and randomized evidence support topical ruxolitinib cream and NB-UVB, with both modalities applicable to patients with richly pigmented skin.[4,5]

CASE PRESENTATION

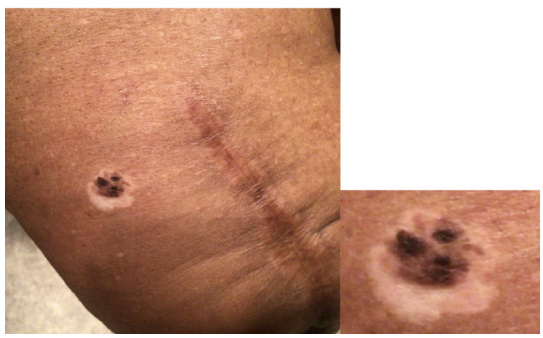
A 73-year-old woman with Fitzpatrick skin type V presented for progressive hypopigmentation. Depigmented patches began on the buttocks three years earlier, with later involvement of hands and feet. She also reported a stable, brownish-black, three-tone macule on the right anterior thigh present for nearly two decades, but within the past year, it developed an enlarging depigmented ring.

On examination, there was an 8–10 mm smooth, brownish-black, three-tone macule on the right anterior thigh that was encircled by a sharply bordered depigmented halo. Additional well-demarcated depigmented macules and patches were observed on the buttocks, hands, and feet.

A horizontal excision under local anesthesia was performed. Histopathology demonstrated classic SK morphology without atypia or malignancy, confirming a benign SK with a halo phenomenon.

The patient was reassured. Vitiligo management was discussed, including photoprotection, topical calcineurin inhibitors, NB-UVB phototherapy, and topical ruxolitinib 1.5% cream applied twice daily.[4,5]

FIGURE 1. Clinical image of the right anterior thigh showing waxy, medium-brown macule with a sharply demarcated depigmented halo in a patient with Fitzpatrick Skin Type V skin and concurrent vitiligo.



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Differential Diagnosis

The differential diagnosis for a haloed papule in an adult is broad. A halo nevus is most often seen in children and adolescents, but when it develops later in life, it warrants careful evaluation, given the reported risk of associated melanoma within one year of diagnosis.[4] Melanoma itself may also resemble seborrheic keratosis, and in such cases, dermoscopy is critical because features such as an atypical pigment network or blue-black and blue-white structures favor melanoma, whereas seborrheic keratosis more commonly displays milia-like cysts, comedo-like openings, and cerebriform ridges.[2,6] Rare cases of halo eczema have also been documented around seborrheic keratoses, producing an inflammatory halo without true regression.[7] In patients with richly pigmented skin, additional diagnostic challenges exist, as clonal seborrheic keratosis can mimic pigmented basal cell carcinoma under dermoscopy, reinforcing the need for histopathologic confirmation.[3]

DISCUSSION

The halo phenomenon, usually linked to melanocytic lesions, has also been documented in non-melanocytic growths such as SK, albeit rarely.[1] Dermoscopy is indispensable: benign SK hallmarks (milia-like cysts, comedo-like openings, cerebriform fissuring) contrast sharply with melanoma clues (blue-white/blue-black areas, atypical network).[2,6] Where findings are equivocal, a biopsy provides a definitive diagnosis.[2]

For vitiligo management, topical ruxolitinib cream demonstrated significant repigmentation in phase 3 trials,[4] while NB-UVB remains a cornerstone therapy, with RCT data supporting its use alone or combined with topical corticosteroids for localized disease.[5] These therapies are effective across skin types, though counseling must address expectations and psychosocial burden, particularly in patients with darker skin.

This case underscores that halo SK, though rare, should be considered in the differential diagnosis for haloed pigmented lesions in adults. Awareness of this presentation, especially in patients with skin of color, is essential to avoid unnecessary excision while ensuring melanoma is not overlooked.

DISCLOSURES

Written consent for publication of de-identified case details and images was obtained. IRB approval was not required for this single-patient, de-identified report. The authors have no relevant disclosures to declare.

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