Lymphangiomas are congenital lymphatic malformations and cutaneous lymphangioma circumscriptum, is now described as superficial lymphatic malformation (SLM).1

The most common type of lymphangioma, cutaneous lymphangioma circumscriptum, is now described as superficial lymphatic malformation (SLM).2

It is clinically characterized by clusters of translucent vesicles resembling frog spawn on the skin and its main differential diagnoses are with lymphangiectasis, hemangioma, angiokeratoma, angiosarcoma, metastatic carcinoma to the skin, verrucae, molluscum contagiosum, warts and epidermal nevi.1,3,4,5

Multiple dilated lymphatic channels usually located in the superficial dermis characterize it histologically. The condition often extends into the epidermis, which can be acanthotic, and a stromal lymphocytic infiltrate is present.6

Dermoscopic features of SLM were first described as two distinct patterns: yellow lacunae surrounded by pale septa without inclusion of blood; and yellow to pink lacunae alternating with dark-red or bluish lacunae, due to the inclusion of blood, making it a difficult differential diagnosis with haemangioma when a marked content of blood was present.7 These findings were well correlated with histologic features.8

A 17-year-old male was referred to our outpatient clinic for evaluation of an asymptomatic verrucous-like lesion in his right axillary fold, which he had had since the age of 8. It had been treated through cryosurgery for clinical suspicion of molluscum contagiosum. Clinical examination showed an irregular plaque involving vesicles with serous and serohematric filling, maximum dimensions of 7x2cm and two vesicular satellite lesions, also with serohematic filling (Figure 1).

Dermoscopy showed red and pale areas with hypopyon-like lesions and whitish, yellowish lacunar areas with thin linear vessels (Figure 2).

Histology showed thin walled lymphatic vessels in the reticular and papillary dermis, confirming the diagnosis of superficial lymphatic malformation (Figure 3).
Electrodessication was performed, leading to a good cosmetic result, without recurrence after a 3-month follow-up.

Cutaneous lymphangioma is clinically defined by a clustering of vesicles with varying content in blood. In dermoscopy, this features as brownish lacunae limited by pale septa or reddish areas in some lagoons, depending on the blood content. A new pattern has recently been described in addition to the pink diffuse coloration and reddish to violaceous lacunar structures. As sedimentation of blood occurs, its corpuscles aggregate according to their density, with cellular components lying at the bottom and serum at the upper part, leading to a color transition from dark to light in some lacunae, creating a similar effect to that seen on the eye – the hypopyon. This particular aspect is present in our case, enhancing its reliability as a dermoscopic criterion for the diagnosis.

Although dermoscopy plays a major role in the diagnosis of SLM, histology remains the gold standard for diagnosis and should not be forgotten in the clinical context of an entity with frequent recurrence after treatment and possible differential diagnosis with carcinoma telangiectoides.

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