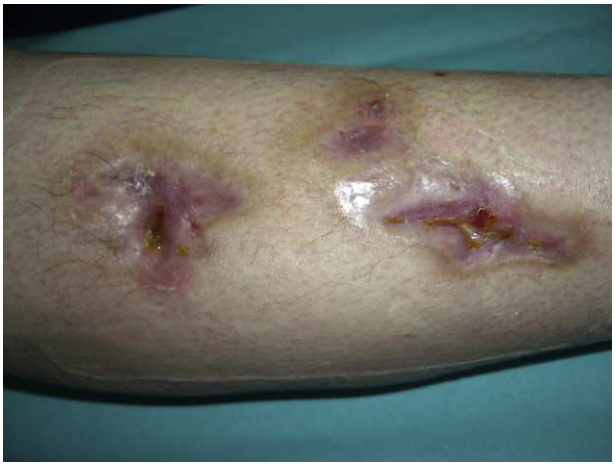

Figure 4 Cutaneous lesions after 3 months. Residual scarring visible on the leg.

Only 23 cases of extensive cutaneous necrosis linked to APS have been reported in the literature.[1,8] Most of the patients have been young women and the underlying diseases included SLE (9 cases), lupus-like disease (1 case), urinary tract infection (2 cases), acquired immunodeficiency syndrome (1 case), rheumatoid arthritis (1 case), mycosis fungoides (1 case), and mixed connective tissue disease (7 cases). Seven patients had no underlying disease. All of the patients developed thrombotic complications limited to skin, and, as in our patient, the lower limbs were the most commonly affected site. Skin biopsy revealed the presence of thrombi in dermal venules and capillaries, with no evidence of vasculitis.

The mechanisms of thrombosis associated with antiphospholipid antibodies remain unknown.[3] The main entities to take into consideration in the differential diagnosis are catastrophic antiphospholipid antibody syndrome and disseminated intravascular coagulation.

Our patient achieved complete healing with prednisolone at a dose of 1 mg/kg/d and heparin, which was replaced by oral anticoagulants at discharge. At the time of writing, after 1 year of follow-up, there have been no further thrombotic episodes.

We conclude that widespread cutaneous necrosis is a rare initial manifestation of APS and should be considered a major thrombotic event.[3] It is important to recognize these lesions because early diagnosis enables early treatment, and, possibly, better prognosis.

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Metastatic Melanoma of the Tongue: A Rare Case

Melanoma metastásico de la lengua: un caso raro

To the Editor,

Cutaneous melanoma is an extremely aggressive malignant tumor arising from melanocytes and accounting some 15% of all cancers. Incidence varies from 3–5 cases per 100 000 inhabitants and year in the Mediterranean region to 12–20 cases per 100 000 inhabitants and year in Nordic countries, and is still increasing worldwide. Cutaneous melanoma is believed to be a cancer that primarily affects white skin, and the risk of developing these tumors is 10 times higher in white-skinned populations than in those with darker skin.[1,2] Melanoma is known for its aggressiveness, and metastases to bones, lungs, brain, liver, or lymph nodes are expected. However, there have been very few reports of oral metastases,[3] which mainly affect the gingiva, tongue, tonsils, and mandible.[4,5]

We describe the case of an 86-year-old white man admitted with a black lesion on the tongue that had persisted for about 2 months. During the consultation, the patient rejected the idea that he had a disease and complained about the appearance, concurrently with the lingual lesions, of

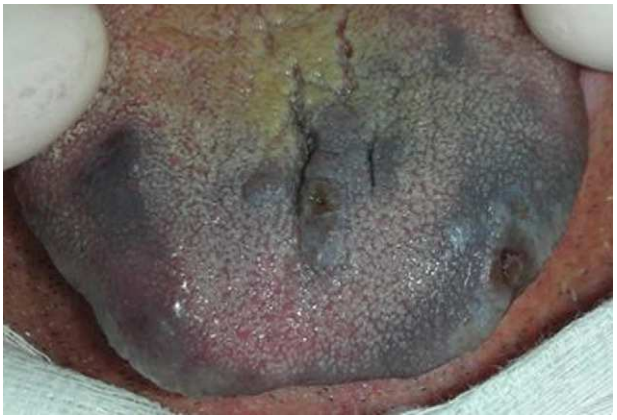

Figure 1 Macular lesion on the dorsum of the tongue associated with small, stiff nodules with an ulcerated-surface located on the left margin and the midline of the anterior third of the tongue.

dark nodules on his neck and upper limbs associated with intense and persistent itching, which had on occasion spread to the trunk. These skin lesions had been treated with antihistamines and topical corticosteroids prescribed initially by his family physician and subsequently by a dermatologist, without clinical improvement. Intraoral examination revealed the presence of a wide, irregularly shaped, sepia-black macular lesion that was firm to the touch and asymptomatic, extending from the dorsal to the ventral surface of the tongue. This was associated with small stiff nodules with an ulcerated surface on the left margin and the midline of the anterior third of the tongue (Fig. 1). Extraoral examination (Fig. 2A and B) revealed the presence of blackish oval nodular lesions, palpable and painless, localized to the neck and upper limbs. A diffuse cervical lymphadenopathy was also detected. These clinical findings gave rise to a suspected diagnosis of oral melanoma. While considering it important to establish whether the oral lesions were primary or metastatic, we preferred to start the diagnostic work-up of the suspected melanoma with an examination of the skin lesions. The results of routine blood tests were

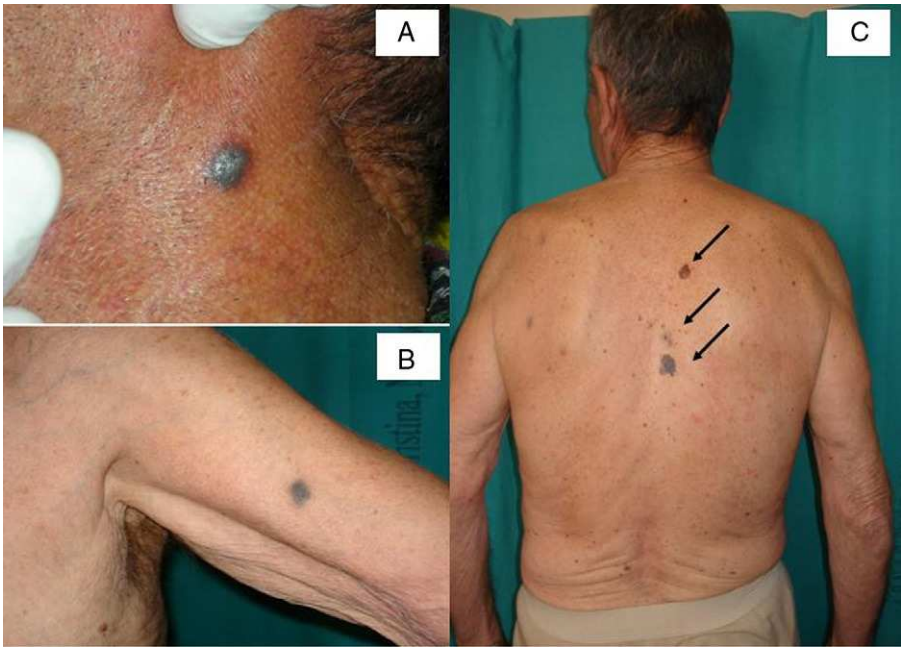

Figure 2 (A) and (B) Oval, blackish, palpable, and painless nodular lesions on the neck and upper limbs. (C) Pigmented skin lesions localized on the spinal column and parascapular region (arrows, from the top to the bottom).

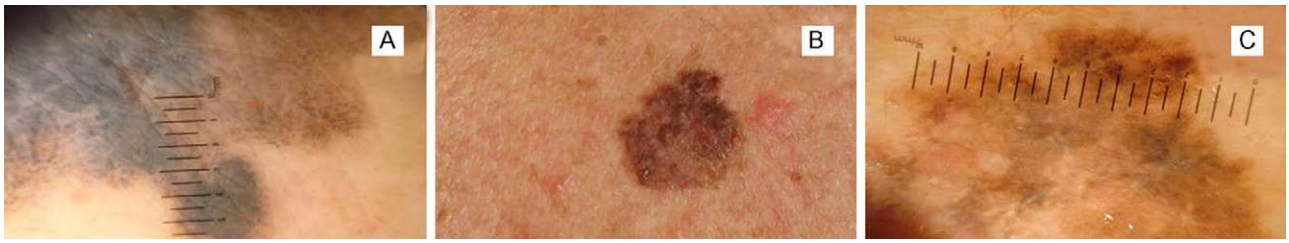

Figure 3 (A) Dermoscopic image of the lesion localized on the spinal column and parascapular region; note the in-transit metastases. (B) and (C) Dermoscopic images of the parascapular brown lesion with regression areas.

within normal limits, with the exception of an increased erythrocyte sedimentation rate. Tests for neoplastic markers revealed the carcino-embryogenic antigen. A more detailed clinical and dermoscopic examination of the skin (Fig. 2C) revealed the following findings: *a*) a brown-black variegated pigmented nevus on the spinal column between the shoulders, irregular in shape and color measuring 21 × 16 mm (Fig. 2C, third arrow) and characterized by a blue–gray veil and irregularly shaped globules; the presumptive diagnosis was melanoma with in-transit metastases (Fig. 3A); *b*) 3 pigmented blue-brown lesions (Fig. 2, C, second arrow) situated 14 mm from the first lesion; and *c*) an irregularly shaped variegated brown lesion on the right parascapular region, of 14 × 15 mm (Fig. 2C, first arrow) characterized by a fragmented thickened network and areas of regression, consistent with the diagnosis of melanoma (Fig. 3B and C). Histopathology examination of an incisional biopsy of the parascapular lesion showed a dermis colonized by atypical epithelioid cells indicating a melanoma (Fig. 4). Unexpectedly, after the diagnosis of cutaneous melanoma was confirmed, the patient refused to undergo oral biopsy.

A diagnosis of cutaneous melanoma with oral metastases was confirmed on the basis of the clinical, dermoscopic, and histological data. A chest radiograph demonstrated no active parenchymal lesions.

A computed tomography scan of the maxillofacial region, neck, brain, thorax and abdomen revealed no further metastases, but generalized lymphadenopathy. Due to the presence of in-transit metastases, sentinel lymph-node biopsy was not performed, as recently reported.[6]

The patient was referred to an oncology unit, but no therapeutic regimen was undertaken given his age, his refusal to consent to treatment, and the number and extent of his lesions.

Melanoma is a tumor caused by the malignant transformation of melanocytes, a cell line derived from the neuroectoderm. Although the skin continues to be the most frequent site of primary disease (95% of cases), the embryologic origin of melanocytes explains why melanoma is not exclusively a skin cancer.[1] In fact, melanomas may also arise in extracutaneous sites, including the mucosal surfaces of the respiratory, gastrointestinal, and genitourinary tracts and other sites where neural crest cells migrate.[7]

The appearance of a primary melanoma located in the oral cavity is very rare, accounting for only 1–2% of all mucosal melanomas and 0.5% of all oral malignancies; secondary or metastatic forms are even more rare.[3,8] When the maxillofacial region is involved, metastases of cutaneous melanoma are mainly reported in the tongue, tonsils, mandible, gingiva, and parotid glands.

When a patient presents with a pigmented oral lesion, an extraoral clinical examination should be performed; in fact, according to Greene and coworkers,[4,9] in order to consider an oral melanoma as primary, the following 3 criteria must be met: *a*) demonstration of melanoma only in the oral cavity; *b*) presence of junctional activity; and *c*) inability to demonstrate extra-oral primary melanoma.

In our case, the presence of a cutaneous lesion with a histopathological diagnosis of melanoma allowed us to consider the oral lesions as metastatic.

When analyzing a suspicious skin lesion, it is important to bear in mind the ABCD rule in which A refers to asymmetry, B to border irregularities, C to color heterogeneity, and D to dynamics (in color, elevation, or size).[2] Furthermore, it has been noted, that dermoscopy always enhances the diagnostic accuracy and identifies lesions that must be biopsied,[10] as was the case in this patient.

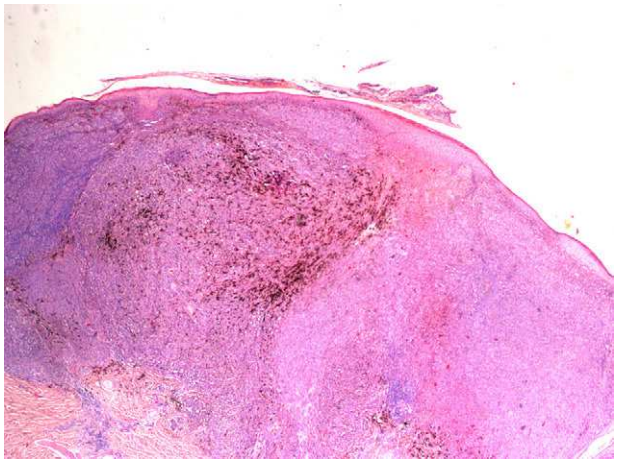

Figure 4 Histological features of a biopsied specimen of the parascapular lesion.

In conclusion, the appearance of a metastatic lingual melanoma is a very rare event, hence close collaboration among different specialists is very important in case of suspicious pigmented lesions to ensure their early detection and a prompt treatment of such aggressive neoplasm.

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Un nuevo marcador dermatoscópico de tinea capitis: «pelos en coma»

Comma Hairs: A New Dermoscopic Marker for Tinea Capitis

La principal aplicación de la dermatoscopia es la valoración de las lesiones pigmentadas. Sin embargo, en los últimos años han aparecido un número muy importante de publicaciones en la literatura en las que se demuestra su utilidad en el estudio de las enfermedades del pelo y del cuero cabelludo[1]. Aunque la mayoría de estudios dermatoscópicos se centran en los hallazgos típicos de algunos tipos de alopecia, especialmente la alopecia areata y la alopecia androgenética[1,2], recientemente se ha descrito la presencia de los «pelos en coma» como un marcador característico de la *tinea capitis* (TC)[3]. La TC o infección por dermatofitos del cuero cabelludo sigue siendo una enfermedad relativamente frecuente en nuestra práctica clínica habitual. Debido a que se presenta mayoritariamente en niños, generalmente entre los 3 y 7 años de edad[4], la tricodermatoscopia puede ser una herramienta diagnóstica muy útil por ser rápida, fiable, barata e inocua[5]. Describimos el caso de dos pacientes afectos de una TC con múltiples pelos en coma como hallazgo dermatoscópico característico.

El primer caso clínico corresponde a un varón de 9 años, natural de un pueblo de Bolivia, donde estaba en contacto frecuente con animales, que consultó por presentar lesiones en el cuero cabelludo y en la cara de 10 meses de evolución. En la exploración física destacaba una fina descamación blanquecina en el cuero cabelludo y varias placas alopécicas en las que existía una marcada fragilidad capilar a la tracción manual. En la cara mostraba también algunas placas eritematosas y descamativas, de contornos irregulares pero bien definidas. No se palparon adenopatías laterocervicales. En el estudio dermatoscópico de las estructuras foliculares se observaron múltiples pelos rotos, así como pelos con una marcada angulación final, con un grosor y una pigmentación homogénea que adoptaban una característica morfología en coma (fig. 1). El examen micológico mediante hidróxido potásico y el cultivo microbiológico permitió confirmar la presencia de un hongo zoofílico identificado como *Trichophyton verrucosum*. El paciente fue tratado con griseofulvina oral a dosis de 20 mg/kg/día durante 8 semanas. En la revisión realizada 4 meses después de comenzar el tratamiento mostraba una curación completa y sin lesiones residuales de alopecia cicatricial.

El segundo caso clínico es el de un varón de 2 años procedente de Senegal, que consultó por varias placas alopécicas en el cuero cabelludo de 6 meses de evolución. La pilotracción manual fue positiva. En el estudio dermatoscópico también se observaban múltiples pelos que presentaban una característica morfología en coma, con pigmentación y grosor homogéneo y una angulación distal abrupta (fig. 2). El estudio micológico mediante hidróxido potásico resultó posi-

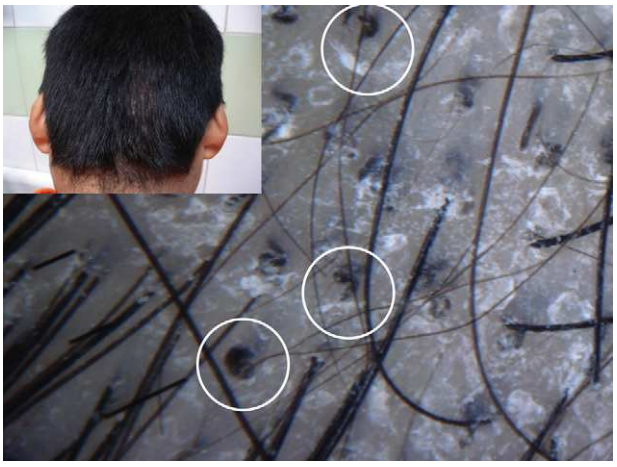

Figura 1 Placa alopécica descamativa en la región occipital. Detalle de la tricodermatoscopia con varios «pelos en coma» (círculos) (dermatoscopio de mano Dermlite II Pro, cámara Sony DSC-W55®, × 40).

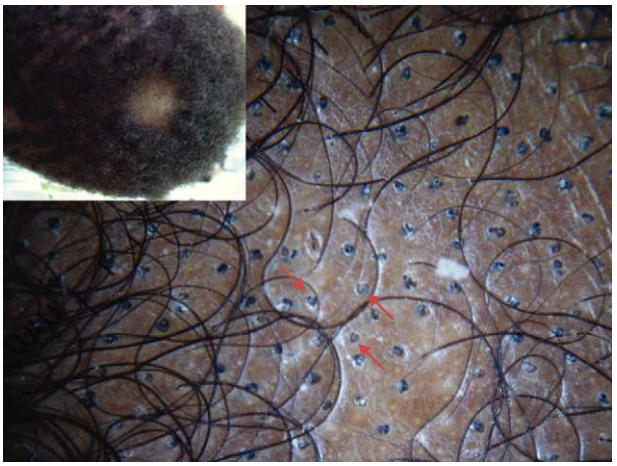

Figura 2 Región parieto-occipital con varias placas alopécicas. Presencia de numerosos «pelos en coma» (flechas) en la imagen tricodermatoscópica (dermatoscopio de mano Dermlite II Pro, cámara Sony DSC-W55®, × 20).