Actas Dermosifiliogr. 2011;102(6):467–479

ACTAS
Dermo-Sifiliográficas

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CASE AND RESEARCH LETTERS

Multiple Clustered Dermatofibromas: An Atypical Presentation of a Common Disease☆

Lo común a veces puede ser atípico: dermatofibromas múltiples agrupados

To the Editor:

Dermatofibroma is the most common fibrohistiocytic tumor of the skin and one of the benign neoplasias that generates most visits to the dermatologist. It usually presents as an isolated lesion and rarely occurs as multiple lesions. The term multiple dermatofibroma is defined either as the appearance of at least 15 dermatofibromas within a few months[1] or, more recently, as 5 to 8 dermatofibromas in 4 months.[2] In 1984, Dupré et al[3] described another form of presentation that is far less common: multiple clustered dermatofibromas. We report a new case of this rare condition. A 25-year-old woman was seen in our department for small, erythematous papular lesions, with a dark center and paler borders, and asymptomatic, residual hyperpigmented macules in smaller numbers, all located on the medial surface of the right thigh. The lesions had appeared at 1 year of age, increased in number and size over 2 to 3 months, and subsequently remained stable except for partial remission of isolated lesions (Fig. 1). The patient reported no general or local history of interest. She brought a magnetic resonance imaging scan that had been performed previously to rule out lymphangioma and that showed no atrophy of the adipose tissue or muscle, and no other relevant alterations.

Biopsy of a lesion revealed epidermal hyperplasia and a proliferation of spindle cells arranged in fascicles or whorls interspersed in bundles of thickened collagen in the underlying reticular dermis (Fig. 2). Immunohistochemistry showed an intense, diffuse expression of vimentin and factor XIIIa. Smooth muscle actin, muscle-specific actin, and CD34 were negative. After histopathological confirmation of the diagnosis of dermatofibroma, it was decided to follow up the patient but to apply no treatment.

We have found 13 cases of multiple clustered dermatofibromas described in the literature, the majority of which were reported in the review by Gershtenson.[4] There is no clinical, histological, or phenotypic differentiation between the individual lesions of multiple clustered dermatofibroma and isolated dermatofibroma lesions. No local triggering factors have been described and, unlike multiple dermatofibromas, no association has been found with states of immunosuppression or other comorbid conditions. Only on 1 occasion did the lesions arise over a thrombosed superficial vein in a patient who had undergone kidney transplantation 1 month earlier. In most of the articles published the lesions had appeared on lower limbs, as was the case in our patient. Apart from our case and 1 case of congenital lesions,[5] the dermatofibromas developed in patients up

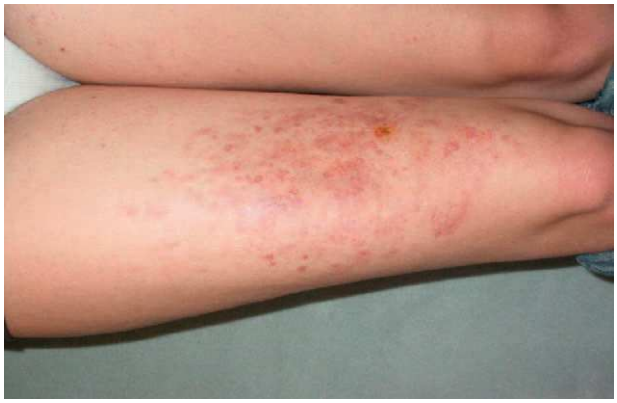

Figure 1 Shiny, erythematous papules on the medial surface of the right thigh.

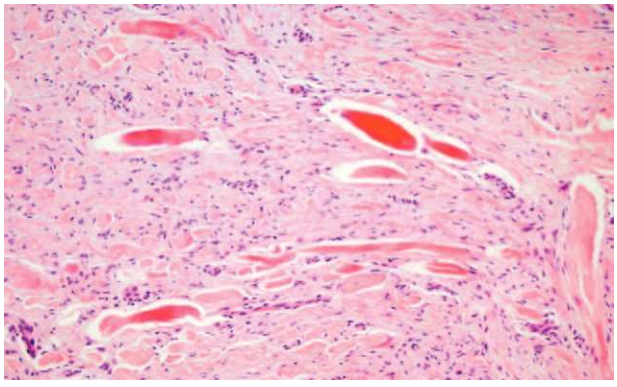

Figure 2 Proliferation of spindle cells between keloid-like collagen fascicles (hematoxylin-eosin, original magnification x150).

☆ Please cite this article as: Castellanos-González M, et al. Lo común a veces puede ser atípico: dermatofibromas múltiples agrupados. Actas Dermosifiliogr.2011;102:467-479.

to 30 years of age. A benign course was reported for all patients and no malignant change or secondary metastases have been described to date. Berbis[6] reports a case followed for 20 years without complications. We believe it is important to bear this in mind for the management and follow-up of this condition.

In our patient, the symptoms, distribution of the lesions, and histopathology were identical to those previously described in the literature, although the onset of the condition at an early age is noteworthy.

In conclusion, we highlight the atypical presentation of multiple clustered dermatofibromas, a subgroup of a very common condition as is dermatofibroma, and its benign course in all the cases described to date.

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M. Castellanos-González,[a,*] J.L. Rodríguez-Peralto,[b] C. Zarco,[a] P. Ortíz-Romero[a]

[a] *Departamento de Dermatología y Venereología, Hospital Universitario 12 de Octubre, Madrid, Spain*
[b] *Servicio de Anatomía Patológica, Hospital 12 de Octubre, Madrid, Spain*

[*] Corresponding author.
E-mail address: maria.castellanos.gonzalez@gmail.com (M. Castellanos-González).

Occupational Contact Dermatitis Due to an Acrylic Resin (ThreeBond): 4 Cases in the Same Company☆

Dermatitis de contacto profesional por Threebond®. Cuatro casos en la misma empresa

To the Editor:

Acrylic resins are thermoplastic polymers or copolymers of acrylic acid or its esters. Acrylic monomers, with initiators, accelerators, and catalysts as additives, are polymerized in 1 of 2 ways: by exposure to ambient temperature, UV or visible light, or electron beams; or by heating.

Acrylic resins can cause a range of skin problems, including allergic contact dermatitis, irritant contact dermatitis, and contact urticaria.

In 1998, Björkner[1] published a classification of acrylic resins that is widely accepted and with which we concur. That classification includes monoacrylates, monomethacrylates, multifunctional acrylates, prepolymers, acrylonitrile, acrylamide and derivatives, and cyanoacrylates.

Multifunctional acrylates are used for dental and orthopedic prostheses, glues, adhesives, varnishes, artificial nails, dyes and inks, printing plates, parquet and wood flooring, and sealants for the automotive and iron and steel industries (Loctite, Threebond, and Sta-Lok).

The most important multifunctional acrylates in terms of frequency of sensitization are as follows: hydroxyethyl methacrylate (HEMA), hydroxypropyl methacrylate (HPMA), etyleneglycol dimethacrylate (EGDMA), diethylene glycol dimethacrylate (DEGDMA), trimethylolpropane triacrylate (TMPTMA), triethylene glycol dimethacrylate (TREGDMA), and butanediol dimethacrylate (BUDMA).

We report 4 cases of eczematous allergic contact dermatitis in workers employed in the same company. The dermatitis, which affected both hands, was the result of sensitization to acrylic resins contained in a sealant called Threebond (Fig. 1).

In October 2009 our skin allergy unit was asked to perform a study of 4 patients who worked in the same motorcycle assembly company. The clinical appearance of the palms and between the fingers of both hands was identical in all 4 patients, with extremely pruritic lesions consisting of long-standing vesicles and blisters. The patients obtained sick leave from work and received standard treatment with antihistamines and corticosteroids (topical for 3 patients and oral for 1 patient). The lesions became cracked and scaly and eventually healed. On returning to work, 3 of the patients experienced immediate relapses (the fourth patient had changed jobs). The 4 patients had been in contact with oils and greases, and also with the Threebond sealant resin, which the patients themselves attributed as the cause of their dermatitis. Although the use of special protective gloves, made of thick cloth, was mandatory in the company, all 4 patients admitted that they had occasionally failed to use them.

The 3 patients who experienced a relapse were 35, 40, and 32 years old, and their lesions had developed within 1.5 months, 1 year, and 10 months, respectively, of starting to work with the sealant. As mentioned above, the fourth patient had changed jobs, and so was not included in our study.

☆ Please cite this article as: Romaguera C, et al. Dermatitis de contacto profesional por Threebond©. Cuatro casos en la misma empresa. Actas Dermosifiliogr.2011;102:468-469.