

Figure 2 (A) Double M-plasty design for a suspected melanoma lesion. (B) Scar of the primary site of a malignant melanoma is clearly identifiable after a double M-plasty.

Conflict of interest

Authors declare no conflict of interest.

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Basal Cell Carcinoma With a Cylindromatous Phenotype[☆]



Carcinoma de células basales con fenotipo cilindromatoso

To the Editor:

Basal cell carcinoma (BCC) is the most common type of skin cancer and is also one of the most common forms of neoplastic disease generally. Although it is not usually very difficult to diagnose BCC, the multiple morphologic variants of the disease can give rise to various—and in some cases compromised—differential diagnoses. One such variant is the cylindromatous pattern or phenotype, which has been described only rarely in the literature and is not mentioned in the main dermatopathology textbooks.^{1–3}

A 91-year-old man with skin phototype II consulted with our dermatology department for an erythematous, nonulcerated papule on the left cheek that had appeared 4 months earlier and had a maximum diameter of 1 cm. A clinical diagnosis of BCC was established and the lesion was excised. Histologic examination revealed an extremely thin, monostratified epidermis under focal pressure from numerous geographic basaloid nodules in the dermal layer that reached the depth of the dermal-hypodermal junction (0.5 cm) (Fig. 1). The surfaces of the proliferating geographic nests were joined to the stratum basale, from which they appeared to originate. The lesional cells showed mild-to-moderate atypia and were arranged in palisades on the periphery of the nodules, which were surrounded by retraction artifact (Fig. 2). Although there were cystic changes in some basaloid nodules, in others a striking cylindromatous pattern was present. The cylindromatous pattern was defined by the presence of an intensely collagenized and hyalinized stroma around the tumor nodules, with the presence of hyaline prolongations extending toward the center of the nodules, forming well-defined terminal cylinders and creating an appearance similar to that of cylindromas

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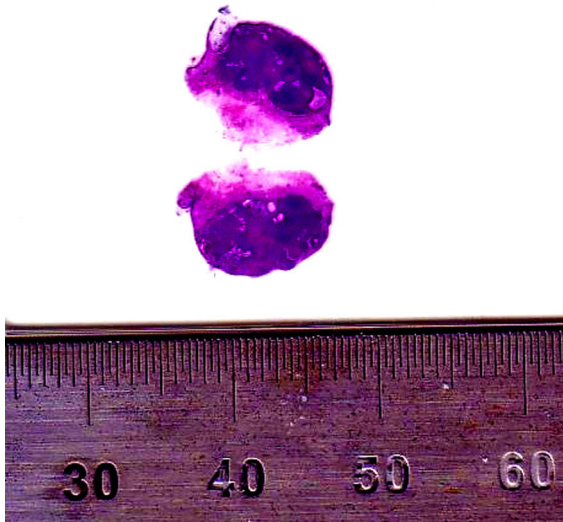


Figure 1 Basal cell carcinoma with a cylindromatous pattern. Macroscopic and microscopic image showing basaloid cells infiltrating the dermis.

(Fig. 3). With the application of periodic acid–Schiff and Alcian blue staining techniques, the cylindromatous structures were stained magenta while the cystic structures were stained blue, demonstrating their mucinous content. An intense lymphocytic infiltrate was observed in the peritumoral stroma. On the basis of these findings, a diagnosis of nodular BCC with a cylindromatous phenotype was established. The recommended treatment, excision with free margins, was sufficient. The lesions have not recurred after 1 year of follow-up.

The cylindromatous component can be present in addition to any of the classic BCC patterns, which would provide

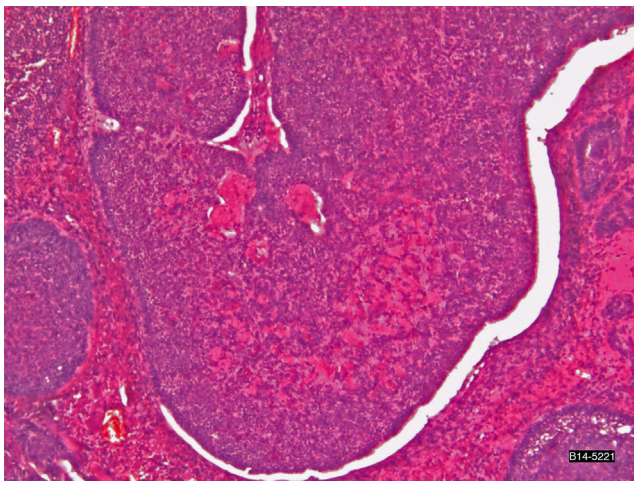


Figure 2 Basal cell carcinoma with a cylindromatous pattern. Detail of a tumor cell nest composed of basaloid cells forming peripheral palisades surrounded by retraction artifact. Abundant amorphous, hyaline, basement-membrane-type material is observed inside the tumor (hematoxylin-eosin, original magnification $\times 100$).

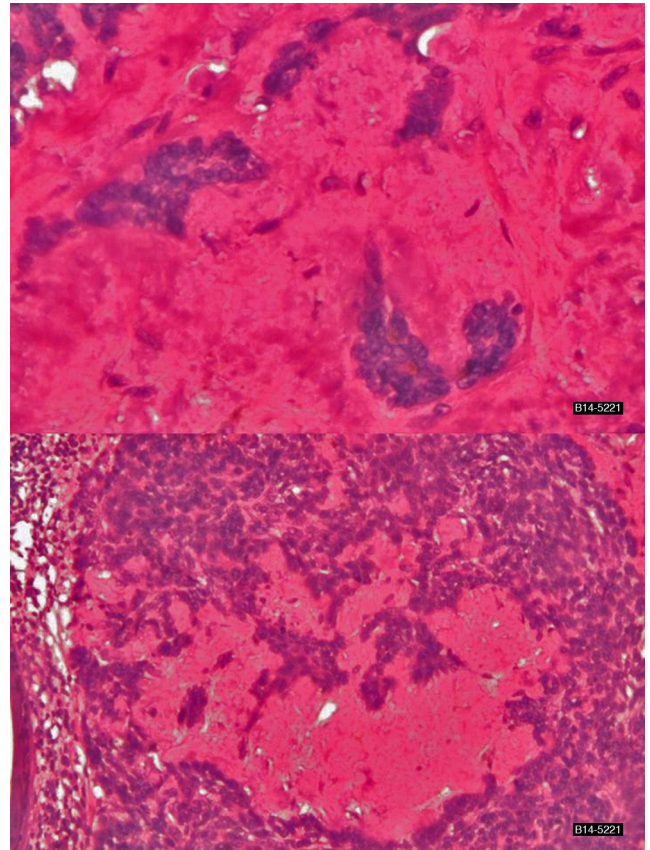


Figure 3 Basal cell carcinoma with a cylindromatous pattern. Both images show various tumor areas characterized by the presence of amorphous, hyaline material surrounded by basal cells with mild-to-moderate atypia (hematoxylin-eosin, original magnification $\times 200$ and $\times 400$).

a clue to the correct diagnosis.^{4–6} The cylindromatous component can be predominant in some cases (as in our patient) or can be the only component present. In such cases, it is useful to check for nuclear atypia, which is mild-to-moderate in BCC and absent in common cylindroma, the main histologic differential diagnosis. The presence of peripheral palisading and retraction artifact around the tumor cell nests, although nonspecific, is useful in making a differential diagnosis with adnexal lesions that have a cylindromatous phenotype.¹ One such lesion is cylindromatous carcinoma, which, as is common in malignant adnexal neoplasms, exhibits greater cellular pleomorphism, frequent mitotic figures, some atypias, and foci of necrosis—rare findings in BCCs. Immunohistochemical techniques do not appear to play an important role in the diagnosis of neoplasms with a cylindromatous pattern.^{1–3}

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Adalimumab-Induced Pityriasis Lichenoides Chronica That Responded Well to Methotrexate in a Patient With Psoriasis[☆]



Pitiriasis liquenoide crónica inducida por adalimumab en paciente con psoriasis y buena respuesta a metotrexato

To the Editor:

Biologic therapy is widely used in the treatment of psoriasis, and the incidence of adverse cutaneous effects induced by tumor necrosis factor (TNF) α antagonists is increasing.¹ A wide range of skin lesions, with variable morphologic features and causes, have been reported in addition to injection site reactions and skin infections. Of particular note is the increasing number of reports of immune-mediated paradoxical reactions, such as psoriasis and psoriasis-like rashes.² Only 5 cases of lichenoid reactions associated with TNF- α antagonists, however, have been reported to date.

We present the case of a 45-year-old hypertensive, diabetic man, with no known allergies, who had a history of unstable moderate to severe plaque psoriasis of 20 years' duration associated with psoriatic arthritis of 3 years' duration. The patient had been treated with topical drugs (various), systemic therapy (oral acitretin), and subsequently, biologic therapy (etanercept—interrupted at 15 months due to a loss of effectiveness—and ustekinumab—interrupted at 9 months due to lack of indication for use in psoriatic arthritis at the time of diagnosis). The patient, with a Psoriasis Area and Severity Index (PASI) score of 12 and a body surface area score of 18, eventually continued treatment with adalimumab 40 mg, and achieved PASI 0 at 8 weeks, with resolution of joint pain. Shortly afterwards, he reported the appearance of an intermittent rash consisting of small asymptomatic lesions that did not coincide with the presence of infections or fever

or the use of other medications. The rashes had been believed to be outbreaks of guttate psoriasis for a period of 8 months, and did not resolve on interruption of adalimumab therapy. Examination revealed multiple, small, firm scaling erythematous papules that covered large areas of the trunk and the proximal extremities, with sparing of the palms, soles, and mucous membranes. The lesions were at different stages of development; some were residual pigmented lesions, while others had a lichenoid appearance with thin, superficial micaceous scales (Fig. 1). The diagnosis was revisited, and laboratory tests, including complete blood count, biochemistry, serology, antistreptolysin O, and antinuclear antibodies, were ordered. All the results were negative or within normal ranges. Skin biopsy showed psoriasiform acanthosis with minimal parakeratosis, a discrete perivascular lymphohistiocytic inflammatory infiltrate and extravasated red blood cells, and isolated vacuolar changes in the basal layer, in addition to minimal epidermal lymphocytic exocytosis and isolated necrotic keratinocytes (Fig. 2). These findings were consistent with a diagnosis of pityriasis lichenoides chronica (PLC). It was decided to add methotrexate 15 mg weekly to the existing treatment with adalimumab. The rash resolved at 6 weeks, and the methotrexate dose was subsequently reduced, and the treatment withdrawn at 10 weeks. Three months later, the patient reported new lesions, which were again brought under control with methotrexate. After 6 months of follow-up, the patient remains asymptomatic (Fig. 3).

Many adverse skin reactions have been reported in association with TNF- α antagonists.³ In a recent publication, Newell et al.⁴ reported the development of PLC in a patient with psoriasis after the third infusion of infliximab, and in a later study, Said et al.⁵ published 2 cases of PLC in patients with Crohn disease under treatment with adalimumab. In both cases, complete remission was achieved following the addition of methotrexate. López-Ferrer et al.⁶ also described a case of PLC after the use of infliximab in a patient with ankylosing spondylitis and ulcerative colitis. A favorable response was also observed when methotrexate was added. Finally, Echeverri et al.⁷ published a case of PLC that appeared during week 6 of etanercept therapy in a patient with rheumatoid arthritis. The condition improved with the use of topical corticosteroids. Our case is the sixth report in the literature of PLC induced by a TNF- α antagonist and the first of good response to methotrexate in a patient with psoriasis being treated with adalimumab. Although we

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