

LETTERS TO THE EDITOR

Clinical and Dermoscopic Features of Pigmented Bowen Disease

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To the Editor:

Bowen disease is described as an in situ squamous cell carcinoma that, like other skin tumors, can present as a pigmented tumor, thereby necessitating differential diagnosis with other pigmented tumors.¹⁻⁶

We present the case of a 48-year-old woman with no relevant personal or family history who was referred to the melanoma unit of our department with suspected diagnosis of “perianal melanoma.” She reported that the lesion had appeared approximately 3 years earlier and that it had been growing slowly ever since. Physical examination of the perianal region revealed an asymmetric poorly demarcated multicolor pigmented tumor that measured 3.5 × 2 cm and that was covered with whitish scales (Figure 1). In the dermoscopic examination (FotoFinder system), the only feature characteristic of melanoma was an aggregate of globules of irregular shapes and sizes in one part of the tumor; reticular pigmentation pattern, starburst pattern, and other features indicative of melanoma were not found. In the rest of the tumor, an atypical vascular pattern was observed comprising large, tortuous, irregular structures, some of which were rounded. In the lower part of the lesion, a verrucous whitish surface



Figure 1. xPigmented tumor in the perianal region

could be discerned. Biopsy showed a tumor confined to the epidermis with acanthosis, a certain degree of papillomatosis, markedly atypical cells, and mitotic figures, with a completely intact basement membrane. Immunohistochemical studies using markers such as Melan-A and pancytokeratin cocktail confirmed the nature of the tumor, which was diagnosed as a case of pigmented Bowen disease. We excised the lesion and, 18 months after the procedure, the patient remains asymptomatic.

Bowen disease is a relatively common tumor that is considered to be an intraepidermal squamous cell carcinoma.^{1-3,6} The pigmented forms of this tumor—although uncommon (less than 2% of cases^{1,5})—require differential diagnosis with other pigmented tumors and with melanoma in particular. Although pigmented Bowen disease can appear at any site, it is rarely found in the genital region, and only 3 cases have been described in the literature to date.^{1,4,7} Various etiologic factors have been implicated in the development of the disease, including chronic exposure to UV radiation and arsenic,^{1,2} trauma, ionizing radiation, and human papillomavirus (HPV) infection. Indeed, HPV infection is particularly important in the development of tumors at sites not exposed to sunlight or in areas often infected by the virus, such as the perigenital region.

Dermoscopy is a noninvasive technique that improves diagnostic accuracy in the case of pigmented lesions. Several dermoscopic features of Bowen disease have been described.^{2,3,8-10} The most characteristic and common findings for this tumor are shown in the Table. The most frequently observed such feature in

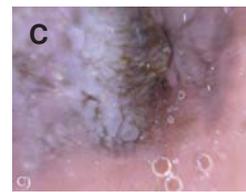
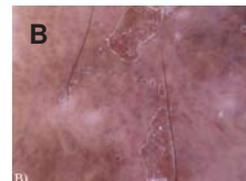
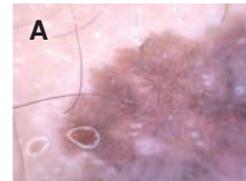


Figure 2. Dermoscopy. A, Brown globules with patchy distribution. B, Atypical vascular pattern. C, Verrucous structure.

Table. Dermoscopic Features of Bowen Disease

Multicomponent pattern
Atypical vascular pattern (glomerular vessels)
No reticular pigmentation pattern
Pigmented pseudonetwork
Irregularly distributed patches of pigmentation
Homogeneous grayish-brown pigmentation
Patchy distribution of dots and globules
Areas of hypopigmentation
Squamous/verrucous surface
Bleeding

Bowen disease is the multicomponent pattern.⁸ Of the criteria presented in the Table, the most specific to Bowen disease are presence of atypical vascular

structures (38.6%-90%) and a squamous or verrucous surface of the tumor (64.2%-90%).^{3,8} The characteristic vascular pattern may include irregular, arborizing, tortuous, or dotted vessels. Some authors consider these vascular structures specific for Bowen disease^{3,9,10} and designate them *glomerular vessels*¹⁰ in view of their particular morphology and their resemblance to vessels of the renal glomerulus. According to those same authors, these vascular structures are similar to the dotted vessels that may be present in amelanotic melanoma, although, in the case of Bowen disease, these structures are larger and have a helical morphology. The pigmented forms of Bowen disease, in addition to the aforementioned criteria, are characterized by the presence of globules (90%) and homogeneous areas of grayish-brown pigmentation (80%).³ These globules are usually smaller than those associated with melanocytic lesions and characteristically follow a patchy distribution in some parts of the lesion. In the case that we present here, 3 of the 4 dermoscopic criteria for pigmented Bowen disease (atypical vascular pattern, squamous or verrucous surface, and patchy distribution of globules) were

met. However, we were unable to confirm the presence of specific glomerular vessels and found instead an atypical vascular pattern. Despite the usefulness of the dermoscopic criteria for diagnosing Bowen disease, we should highlight that all of them may be present in benign melanocytic tumors, seborrheic keratosis, basal cell carcinomas, and melanoma. For this reason, we believe that they are not completely reliable for a correct differential diagnosis with other pigmented lesions, and particularly with melanoma. Histology remains the gold standard for an accurate differential diagnosis. The case we present here reflects the complex nature of diagnosing skin tumors, particularly when they present with clinical and dermoscopic characteristics common to several other tumors at an age when they are uncommon and at an unusual site.

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Eosinophilic Fasciitis After Taking Simvastatin

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To the Editor:

Eosinophilic fasciitis is a rare fibrosing disease characterized by painful, symmetric inflammation of the limbs, and progressive induration of the skin. In some cases, it can also lead to debilitating joint contractures, arthritis, neuropathy, and myositis. The hallmark histologic finding is fascial fibrosis. While eosinophilic fasciitis is considered by some to be a variant of morphea or scleroderma,

others believe it to be a separate entity. The condition is of unknown etiology but it has been associated with a variety of disease processes as well as with exposure to environmental factors, toxins, and certain drugs.

We present the case of a 71-year-old woman with a history of osteoporosis under treatment with bisphosphonates and primary hypercholesterolemia under treatment with simvastatin.

The patient presented with progressive induration of the skin on her arms and legs that had appeared 9 months earlier. She also had asthenia and dyspnea on moderate exertion. The symptoms had appeared 3 weeks after initiation of simvastatin and worsened progressively until the drug was withdrawn 1 month later. The symptoms then stabilized but did not improve.