

structures (38.6%-90%) and a squamous or verrucous surface of the tumor (64.2%-90%).<sup>3,8</sup> The characteristic vascular pattern may include irregular, arborizing, tortuous, or dotted vessels. Some authors consider these vascular structures specific for Bowen disease<sup>3,9,10</sup> and designate them *glomerular vessels*<sup>10</sup> 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%).<sup>3</sup> 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.



**Figure 1.** Diffuse erythema and inflammation of thighs (A) and legs (B) with a dimpled appearance.

Physical examination revealed erythema, induration, and dimpling of the skin on the arms and, particularly, on the legs (Figure 1). There was no evidence of acrosclerosis or of any other skin lesions.

The only other remarkable findings in the laboratory workup were slight eosinophilia ( $0.65 \times 10^9/L$ ) and an elevated erythrocyte sedimentation rate (27 mm/h). All other blood count and biochemistry test results were normal, and the results of serology tests and analysis of rheumatoid factor were negative.

A biopsy of the deep skin layers revealed fibrosis involving the reticular dermis, the septa of the superficial fascia, and reaching the striated muscle; there was also a perivascular and interstitial lymphocytic infiltrate (Figure 2).

Because the clinical and histology findings were suggestive of eosinophilic fasciitis, the patient was administered prednisone (60 mg/d) and methotrexate (5 mg/wk), leading to a gradual improvement of symptoms.

Although the cause of eosinophilic fasciitis is unknown, there are several reports of patients developing it after intense physical exercise. It has also been associated with various hematologic diseases,<sup>1,2</sup> kidney diseases,<sup>3</sup> infections by *Borrelia burgdorferi*,<sup>4</sup> and the administration of certain drugs.<sup>5,6</sup>

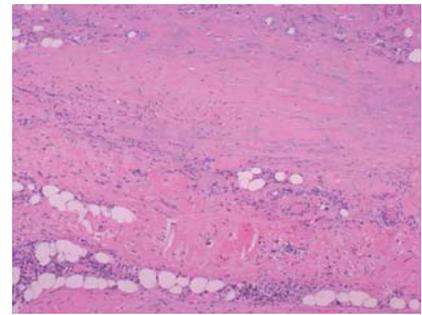
In our case, the fact that the onset of symptoms was temporally associated with the use of simvastatin and that

there were no other potential causative factors suggests that this drug might have triggered the condition.

Two studies have previously reported an association between eosinophilic fasciitis and 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitors,<sup>7,8</sup> and there is growing evidence that, in addition to reducing atherogenesis and cardiovascular morbidity, these inhibitors may have immunomodulatory properties. They reduce the production of proinflammatory type 1 helper T ( $T_H$ ) cells and induce differentiation towards  $T_H2$  cells.<sup>9-10</sup> For this reason, HMG-CoA reductase inhibitors might trigger or exacerbate certain autoimmune diseases such as myasthenia gravis, dermatomyositis, polymyositis, lupus-like syndrome, and lichen planus pemphigoides. They might also, however, be useful for treating other autoimmune diseases and preventing graft rejection in patients who have undergone transplants.

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**Figure 2.** Diffuse fibrosis of the reticular dermis and septa of the superficial fascia, with a perivascular and interstitial lymphocytic infiltrate (hematoxylin-eosin, original magnification  $\times 200$ ).

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