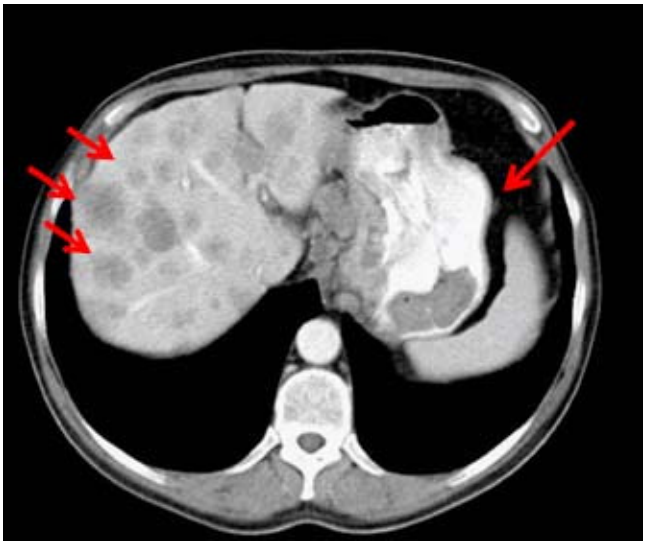

Figure 2 Computed tomography image. Areas of increased uptake compatible with gastric cancer with liver metastases (red arrows).

Table 1 Predictive Factors for Malignancy in Dermatomyositis and Polymyositis

Personal history of a previous tumor
Sudden onset of skin/muscle symptoms
Skin necrosis*
Constitutional symptoms
Laboratory parameters:
Elevated levels of CPK (>1000 U/L)
Low C4 counts (<40 mg/dL)
Elevated p155/140 antibody titer

*Includes epidermal necrosis, digital necrosis (periungual and of the digital pulp), and mucosal necrosis.
Abbreviation: CPK, creatine phosphokinase.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

References

1. Fardet L, Dupuy A, Gain M, Kettaneh A, Chérin P, Bachelez H, et al. Factors associated with underlying malignancy in retrospective cohort of 121 patients with dermatomyositis. Medicine. 2009;88:91-7.
2. Sparsa A, Liozon E, Herrmann F, Ly K, Lebrun V, Soria P, et al. Routine vs extensive malignancy search for adult dermatomyositis and polymyositis: a study of 40 patients. Arch Dermatol. 2002;138:885-90.
3. Callen JP. When and how should the patient with dermatomyositis or amyopathic dermatomyositis be assessed for possible cancer?. Arch Dermatol. 2002;138:969-71.
4. Mahé E, Descamps V, Burnouf M, Crickx B. A helpful clinical sign predictive of cancer in adult dermatomyositis: cutaneous necrosis. Arch Dermatol. 2003;139:539.
5. Chen YJ, Wu CY, Shen JL. Predicting factors of malignancy in dermatomyositis and polymyositis: a case-control study. Br J Dermatol. 2001;144:825-31.
6. Bielsa I. Nuevos anticuerpos en la dermatomiositis. Actas Dermosifiliogr. 2009;100:182-9.
7. Chinoy H, Fertig N, Oddis CV, Ollier WE, Cooper RG. The diagnostic utility of myositis autoantibody testing for predicting the risk of cancer-associated myositis. Ann Rheum Dis. 2007; 66:1345-9.

A. Martorell-Calatayud,* C. Serra Guillén, C. Ciudad-Blanco, and O. Sanmartín

Servicio de Dermatología, Instituto Valenciano de Oncología, Valencia, Spain

*Corresponding author.
E-mail address: antmarto@hotmail.com (A. Martorell-Calatayud).

Dermoscopic findings in solitary reticulohistiocytosis

Hallazgos en dermatoscopia del reticulohistiocitoma cutáneo solitario

To the Editor:

Solitary cutaneous reticulohistiocytosis, initially described by Zak in 1959,[1] is a variant of multicentric reticulohistiocytosis that is limited to the skin. It is a rare condition that is characterized by rapid growth of a single brownish-yellow or reddish lesion, which is usually asymptomatic. It typically presents on the trunk or the limbs, and rarely on the face.[2] Histology is characterized by a dermal infiltrate of histiocytes with an eosinophilic cytoplasm with a ground-glass appearance and prominent nucleoli.[2] An inflammatory infiltrate composed mainly of lymphocytes is also observed. Hyperkeratosis and, occasionally, parakeratosis may be observed. Immune staining is positive for lysozyme, CD68, and CD163 and negative for CD3, CD20, CD30, human melanoma black-45, and keratins. The condition is not associated with other diseases and recurrence after excision is very rare.

We report the case of a 51-year-old man with no relevant personal history other than hypercholesterolemia, which was being treated with simvastatin. He reported the sudden appearance of an asymptomatic papular lesion

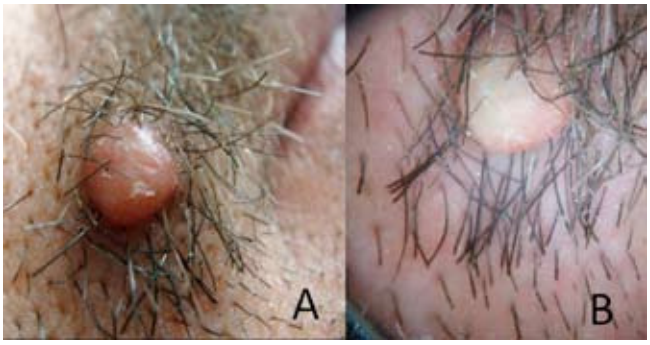

Figure 1 A, Clearly defined pink tuberous lesion, with a smooth surface, little epidermal component, and no adnexa. B, Sign of the setting sun—a dermoscopic image that shows a uniform central yellow area. The color of the periphery is more pink, although there are no dilated capillaries or pigmented reticulum.

2 or 3 months earlier in the right nasolabial fold; the lesion had become slightly smaller in the previous week. There were no systemic symptoms. Physical examination revealed a well defined tuberous lesion with a diameter of 0.7 cm, a smooth, pink surface, and elastic consistency (Figure, panel A). Dermoscopy revealed a poorly defined, uniformly yellow central area, with no dilated capillaries in the periphery, where the lesion was of a pink-orange color (Figure, panel B). There were no palpable lymph nodes, masses, or organomegaly. The lesion was completely excised due to suspected juvenile xanthogranuloma. Histology revealed a proliferation of histocytes in the papillary dermis. These cells had abundant eosinophilic cytoplasm, large nuclei, and, in most cases, prominent nucleoli. Between these cells there was a marked inflammatory component consisting predominantly of eosinophils and neutrophils. Immune staining was positive for CD68 and negative for myeloperoxidase, S100, CD30, CD1a, and CD21. Blood tests revealed only elevated glucose and triglyceride levels (124 mg/dL and 292 mg/dL, respectively). Other biochemistry tests (liver, kidney, and thyroid function tests and lipid profile), immunoglobulins, protein electrophoresis, and urinalysis were normal. Cryoglobulins and cryoagglutinin tests were negative. X-rays of the dorsal, lumbar, and sacral spine and of the hands and elbows revealed no significant findings. In the light of these data, the patient was diagnosed with solitary cutaneous reticulohistiocytoma. No new lesions have appeared during follow-up and the patient remains asymptomatic.

Dermoscopy is a noninvasive technique that provides a better view of the epidermis, the dermal-epidermal junction, and the superficial dermis. The technique is particularly useful for studying pigmented lesions, although its use in other dermatoses such as viral infections (molluscum contagiosum), parasitic conditions (scabies), and inflammatory diseases (lichen planus and psoriasis) is currently being studied.[3]

Xanthogranulomas are characterized dermoscopically by a central yellow-orange area with a slightly more erythematous periphery, similar to that observed in our patient. This finding has been called the sign of the setting sun and is considered indicative of the presence of xanthomatous histiocytes.[4,5] Recently, another article on dermoscopy of solitary yellow lesions reported some additional characteristics that may facilitate the differential diagnosis. Thus, xanthomatous dermatofibromas present a fine pigmented reticulum peripherally and xanthogranulomas show dotted vessels.[6] Dermoscopy of solitary reticulohistiocytoma has been described in a case report, revealing dotted vessels, as with the xanthogranuloma, and light-brown globules, which were hemosiderin deposits, on a yellow background.[6] None of these additional findings were observed in our patient.

We believe that dermoscopy may be useful for guiding diagnosis toward histiocytosis of non-Langerhans cells, particularly in variants in which the histiocytes are xanthomatous.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

References

1. Zak F. Reticulohistiocytoma ("ganglioneuroma") of the skin. Br J Dermatol. 1950;62:351-5.
2. Miettinen M, Fetsch JF. Reticulohistiocytoma (solitary epithelioid histiocytoma): a clinicopathologic and immunohistochemical study of 44 cases. Am J Surg Pathol. 2006;30:521-8.
3. Vázquez-López F, Kreusch J, Marghoob AA. Dermoscopic semiology: further insights into vascular features by screening a large spectrum of nontumoral skin lesions. Br J Dermatol. 2004;150:226-31.
4. Hussain SH, Kozic H, Lee JB. The utility of dermatoscopy in the evaluation of xanthogranulomas. Pediatr Dermatol. 2008;25:505-6.
5. Palmer A, Bowling J. Dermoscopic appearance of juvenile xanthogranuloma. Dermatology. 2007;215:256-9.
6. Cavicchini S, Tourlaki A, Tanzi C, Alessi E. Dermoscopy of solitary yellow lesions in adults. Arch Dermatol. 2008;144:1412.

M. Llamas-Velasco,* E. Gallo, R. Navarro, and J. Sánchez-Pérez

Servicio de Dermatología, Hospital Universitario de la Princesa, Madrid, Spain

*Corresponding author.
E-mail address: mar.llamasvelasco@gmail.com (M. Llamas-Velasco).