

immunocompromised as a result of corticotherapy—the most common risk factor in developing cryptococcosis^{3,4}—although he had no history of trauma. The skin lesions, although uncommon due to their sporotrichoid appearance, were confined to uncovered areas. Serotype D organisms were not identified in our case. Our patient showed no systemic symptoms other than those related to his cancer, and the physical examination and complementary studies did not reveal any extracutaneous diseases. This fact, combined with the rapid resolution of the condition following administration of fluconazole, makes us consider cutaneous cryptococcosis as a primary diagnosis.

Treatment of the primary form is not well established at present.² Initial management tends to be medical, or a combination of medical treatment and surgical excision. Fluconazole (200–400 mg/d) is the most common agent prescribed, on average, for 32 days. For maintenance treatment in immunocompromised patients it is recommended that this drug be replaced with a less toxic alternative.¹ The effectiveness of the therapy was remarkable in our patient, with full healing obtained in less than a month despite immunodepression and the absence of surgical intervention.

In conclusion, we present a new case of primary cutaneous cryptococcosis with an uncommon sporotrichoid presentation in a patient with metastatic cancer on high doses of corticosteroid treatment. We also stress the excellent response to fluconazole.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Acrochordons Caused by Friction From Crutch Use

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To the Editor:

Acrochordons, also known as soft fibromas or fibroepithelial polyps, are the most common type of fibrous skin tumor and affect nearly 50% of individuals.¹ From the clinical viewpoint, they can present as solitary or multiple, pedicled, soft, skin-colored, or pigmented lesions. The most frequent locations are the neck, armpits and groin. Despite their high prevalence, there are few references in the specialized literature to their pathogenesis. The possible

role of mechanical friction in their development has been barely mentioned in the literature. We report a case in which this factor played a clear role in their development. The case concerns a 79-year-old man with a personal history of hypertension, peripheral venous failure, fracture of the left hip during childhood with osteolysis of the proximal end of the femur (which, since this time, has required a crutch for walking), and right hip arthroplasty,



Figure 1. Contact area of the crutch with the left armpit.



Figure 3. Absence of lesions in the right armpit.



Figure 2. Hyperpigmented swollen area with a velvety surface with very numerous soft fibromas on the surface of the left armpit.

and who was referred to our hospital due to lesions in the left armpit that had gradually appeared over decades until becoming very numerous, causing mild irritation due to friction. The lesions were located exactly where the crutch made contact (Figure 1). Physical examination showed a hyperpigmented plaque on swollen skin with marked skin folds and velvety surface, on which there were a large number of pedicled, soft, light-brown lesions (Figure 2). The complete absence of these lesions from the right armpit (Figure 3) and other locations was striking. A biopsy specimen was taken from one of the lesions of the left armpit and showed discrete acanthosis and epidermal papillomatosis with lax dermal stroma, compatible with acanthosis nigricans and acrochordons. The larger fibroepithelial polyps underwent electrosurgery at the same time.

Despite their high rate of presentation in clinical practice, there are few references in the literature to the pathogenesis of soft fibromas. A possible association with colonic polyps has been suggested,² although this has not been confirmed by subsequent studies.^{3,4} Various studies have suggested their association with diabetes mellitus^{5,6} and an atherogenic lipid profile,⁷ and in many cases they are currently considered markers of obesity and insulin resistance.⁸ Nevertheless, there are few references in the literature to the role of friction in the development of these lesions,⁹ although the most typical locations (armpit, neck, and groin) are body areas that are subject to continuous friction.

In our patient, the association between the axillary acrochordons and continuous friction with the crutch surface is clear, due to the topographical coincidence of the lesions with the area used for support as well as the absence of lesions in the right armpit. On the other hand, the concomitant presence in our patient of acanthosis nigricans and soft fibromas in the area undergoing continuous friction—in the absence of obesity or impaired carbohydrate metabolism—calls into question the primacy of metabolic factors versus mechanical factors in the development of these lesions in obese patients. It seems possible that epidermal hyperplasia of acanthosis nigricans as well as the increase of lax collagenous tissue of soft fibromas in many cases merely reflects a chronic adaptive response by the skin to friction.

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Unilateral Nevoid Telangiectasis in a Patient With Chronic Hepatitis B Virus Infection

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To the Editor:

Unilateral nevoid telangiectasis syndrome consists of multiple telangiectasias with a metamer distribution and is considered an essential telangiectasia. Different theories have been suggested regarding its pathogenesis, but the most widely accepted is related to variations in estrogen levels or their receptors. We present a new case of this syndrome, possibly associated with chronic hepatitis B virus (HBV) infection.

The patient was a 47-year-old man who was referred due to asymptomatic erythematous lesions of 2 months duration, located on the right arm, neck, and upper part of the trunk. Of note, he had a personal history of obstructive sleep apnea syndrome and was a former smoker. Physical examination showed multiple vascular

lesions consisting of telangiectasias with a metamer distribution in the upper third of the trunk, neck, and dorsal and external surfaces of the right arm (Figure 1 and Figure 2). Blood analysis demonstrated high cholesterol and triglyceride concentrations, without other findings of note (luteinizing hormone [LH], follicle-stimulating hormone [FSH], dehydroepiandrosterone, sex hormones, or glutamic pyruvic transaminase and glutamic oxalacetic transaminase). However, serological tests were positive for hepatitis B surface antigen (HBsAg), HBV core antibodies and HBV e antibodies, with no detectable viral load, which is consistent with the nonreplicative phase of chronic HBV infection, indicating that the carrier was healthy. There was no evidence of liver cirrhosis.



Figure 1. Posterior view showing the metamer distribution of the telangiectasias.



Figure 2. Anterior view showing how the telangiectasias do not cross the midline.