the etiology of the calcification. Clinical manifestations will also depend on the underlying disorder (if present), but usually there are multiple, hard, whitish papules, plaques, or nodules with a symmetrical distribution.

Morbidity depends on the extent and site of the cutaneius calcification; joints, muscles, and organs such as the lungs, kidneys, and intestine may also be affected. In addition, vascular deposits of calcium can give rise to distal ischemia and necrosis. Areas of ulceration or the transcutaneous elimination of a whitish-yellow, chalk-like matreial may be observed, and secondary infection can develop. The therapeutic measures used depend on the underlying disease; in general the outcomes are not very satisfactory and only the results of case reports are available.

Most medical treatments for calcinosis cutis have been described in patients with connective tissue diseases. They include warfarin, colchicine, probenecid, bisphosphonates, minocycline, and diltiazem.[4-8]

Success has also been reported with other treatment modalities, such as carbon dioxide laser and intralesional corticosteroid injection.[9,10]

Finally, surgery is a possible option to remove calcium deposits in necrotic or infected tissues.

In conclusion, calcinosis cutis is a rarely reported sequela of acne and represents a therapeutic challenge. Clinical suspicion and appropriate additional tests are required to reach the diagnosis.

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Conflicts of Interest
The authors declare no conflicts of interest.

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Melanoma and Retinoblastoma*

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To the Editor:

Retinoblastoma is an embryonal tumor derived from retina cells that affects 5 in every 100 000 newborns and accounts for 3% of cancers in those children aged less than 15 years. It is the most common type of malignant intraocular tumor in children and the second most common for all age groups after melanoma.[1]

Most cases are diagnosed in the first 4 years of life. Presentation is unilateral in 60% to 75% of cases, and 60% are classed as sporadic.[2] The remaining cases are bilateral and mostly hereditary.

Bilateral forms are caused by a double mutation in the Rb gene on the long arm of chromosome 13.[3,4] The

*This case was presented as a poster in the XXXVI National Congress on Dermatology in Barcelona 2008 and was awarded a special mention within the Oncology section

condition presents incomplete autosomal dominant inheritance with high penetrance.[5]

Fifty-one percent of patients with bilateral retinoblastoma develop another cancer at some point in their life, the most frequent being osteosarcoma, followed by rabdomiosarcoma, chondrosarcoma, neuroblastoma, glioma, leukemia, melanoma, and other neoplasms including ovarian, breast, lung, and bladder cancers.

We present the case of a 27-year-old man with a body weight of 155 kg, who underwent enucleation of the right eye for retinoblastoma at 16 months old. Later, at 9 years old, he was diagnosed with another retinoblastoma in the right eye that was treated by enucleation and complementary radiotherapy. His medical history includes poorly controlled psoriasis, as the patient did not apply treatment or attend follow-up sessions.

The family history includes a brother who died from bilateral retinoblastoma at 5 years old and a father diagnosed with unilateral retinoblastoma at 50 years old. There was no history of dysplastic nevi in the family.

In an examination during consultation for psoriasis, an abnormal pigmentary lesion with a maximum diameter of 2 cm was noticed on the lower back (Figures 1 and 2). The lesion had been present for 8 months. The lesion was surgically removed and diagnosed as an invasive melanoma of Clark level III with a Breslow thickness of 1.3 mm, showing no ulceration or areas of regression. No lymph node involvement was palpated. No sentinel lymph node biopsy was carried out due to the anatomical limitations of the patient. The analysis of tumor spread (computerized tomography of the thorax, abdomen, and pelvis) produced no significant findings.

The link between retinoblastoma and melanoma has been described in the literature although the nature of the relationship between the 2 entities has not been identified.[6]

Attempts have been made to establish a link between the predisposition of patients with retinoblastoma to other cancers and radiotherapy or cycles of cyclophosphamide treatment rather than with any genetic tendency to develop mutations.

There are few reported cases of links between melanoma and retinoblastoma. In 2002, Belt[6] carried out a broad review of the literature and found 35 published cases, but some important contributions have come to light since.

Melanoma presents in between 3% and 25% of patients with hereditary retinoblastoma.[7,8] Cases have been reported of bilateral retinoblastoma and melanoma in patients with no family history of retinoblastoma but with a history of melanoma.[9] We have also found cases of bilateral retinoblastoma with melanoma where there is no family history.[1,8] The risk of developing melanoma in families of patients with retinoblastoma is 10 times greater than among the general population.[10]

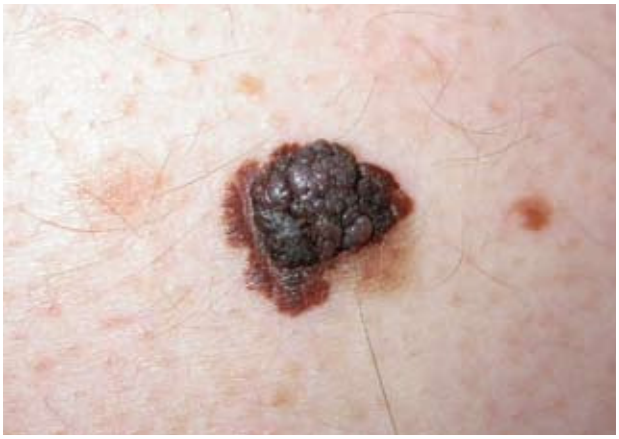

Figure 1. Atypical polychromatic pigmentary lesion with irregular edges and proliferations on the surface.

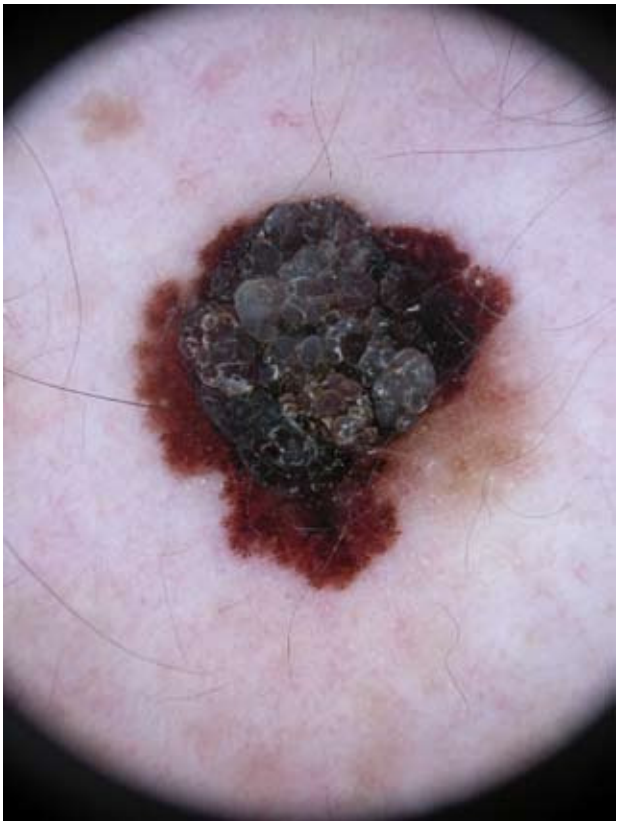

Figure 2. Dermoscopic image showing a highly atypical pigmentary reticule, polychromy, irregular projections, and a blue veil.

The incidence of melanoma increases with age, especially after 20 years of age. Exceptional cases have been reported of melanoma during infancy in patients with retinoblastoma.

The role of radiation in the second carcinoma is not clear. It seems there is increased risk of osteosarcoma and

some forms of brain tumor; although such outcomes have not been demonstrated for melanoma.

The cells of retinoblastoma, melanoma and dysplastic nevus are derived from the neural crest. There are authors who postulate that patients with retinoblastoma and dysplastic nevus syndrome have increased genetic susceptibility to melanoma due to a primary anomaly in the neural crest.

The association between retinoblastoma and melanoma is a controversial issue potentially dependent upon genetic predisposition or the forms of treatment received. Patients with retinoblastoma have an almost 10-fold greater risk of suffering from melanoma than those with no history of retinoblastoma, especially in cases of bilateral or hereditary types. Consequently, close follow-up of these patients is vitally important, especially in patients with associated dysplastic nevus syndrome.

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Parallel Ridge Pattern in Acral Melanoma: Biopsy Processing Technique Can Affect Histological Diagnosis

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Figure 1. Flat, variegated pigmented lesion on the right heel, 2 cm in diameter. Dermoscopy: Dermoscopy ridge pattern.

To the Editor:

The skin on the palms and soles presents anatomical and histological peculiarities suited to the particular pressures exerted upon it. Consequently, differential diagnosis of acral melanocytic lesions based exclusively on clinical and histological criteria can become a very complicated matter. Dermoscopy is a very helpful tool in difficult cases.

We present the case of a 45-year-old patient with no relevant history, of north African origin with phototype IV skin, who consulted for a slow-growing pigmented lesion on the sole of the right foot that had appeared 2 years previously. Examination revealed a well defined variegated macule on the heel, measuring 2 cm across. Dermoscopy revealed this to be a melanocytic lesion with a ridge pattern (Figure 1).