differs in that the patient had no personal or family history of psoriasis and developed lesions in areas other than the site of primary contact. We are unable to explain this. The persistence of a small number of lesions, despite avoidance of contact with rubber additives, would seem to indicate psoriasis triggered by a Koebner phenomenon in an individual with a genetic predisposition. Another possibility is that the psoriasis was triggered by ACD at different sites following contact with the rubber in the gloves (as occurs with ectopic ACD). Finally, considering that we know of no similar cases, the psoriasis might have been induced or triggered by ACD, as occurs with other stimuli such as certain drugs.

We have described a rare clinical case but we would also like to highlight the fact that noneczematous dermatitis might be caused or exacerbated by contact allergy and recommend the performance of patch tests in all cases in which there is a suggestive clinical history.

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Mucoepidermoid Carcinoma of the Lip

Carcinoma mucoepidermoide de labio

To the Editor:

Tumors of the lip, except for squamous cell carcinoma, are rare, and tumors of the minor salivary glands account for less than 2% of all lip tumors.[1] These form a very heterogeneous group of neoplasms; most of them are benign (55%-65%, depending on the series)[2,3] although the benign or malignant nature of the tumors appears to vary according to the anatomic site.[3] Tumors of the minor salivary glands that arise on the palate and in the upper lip tend to be benign, whereas those that develop in the lower lip tend to be malignant.[2] The most common of the malignant tumors are adenoid cystic carcinoma and mucoepidermoid carcinoma.[1]

Tumors of the minor salivary glands occur predominantly in women (female to male ratio of 1.6 to 1)[2] in the fourth to fifth decades of life. The tumors are characterized by endophytic growth and often present a slowly progressive course, which delays the diagnosis.

We describe a 42-year-old woman with no relevant past history who consulted for a painless mass with a diameter of 1 cm on the internal aspect of the lower lip. The mass had first appeared 3 years earlier. The lesion was round, of elastic consistency, and covered by a mucosa of normal appearance. Its growth had been slowly progressive. There were no palpable locoregional lymph nodes. V-excision was performed. Histology revealed a well-delimited submucosal mass that pushed up the mucosa and showed infiltration at the lateral and deep margins. The mass was composed of cords and islets of mucus-secreting, epidermoid, and intermediate cells with variable degrees of differentiation (Figures 1 and 2). Low-grade mucoepidermoid carcinoma was diagnosed.

Mucoepidermoid carcinoma of the oral cavity arises in the ductal epithelium of the major or minor salivary glands. Affected minor glands are most frequently located in the palate, followed by the lower lip.[3] There have been occasional reports of cases of primary cutaneous mucoepidermoid carcinomas considered to originate in sweat glands and also in the vermillion border of the lower lip, where there are no salivary glands.[4] In the latter case, the authors suggested that it was due to metaplasia in a squamous cell carcinoma of the lip and excluded glandular origin. Mucoepidermoid carcinoma is composed of various cell types: mucus-secreting cells that can present variable morphology and that are identified using mucin stains, squamous cells with no evident keratinization, clear cells that contain glycogen and occasionally mucin, and intermediate cells that have the characteristics of basal cells and polygonal squamous cells in terms of size and appearance. The proportion of each cell type and their arrangement within the tumor can be highly variable.[5] Histologic parameters, such as the cystic component, the

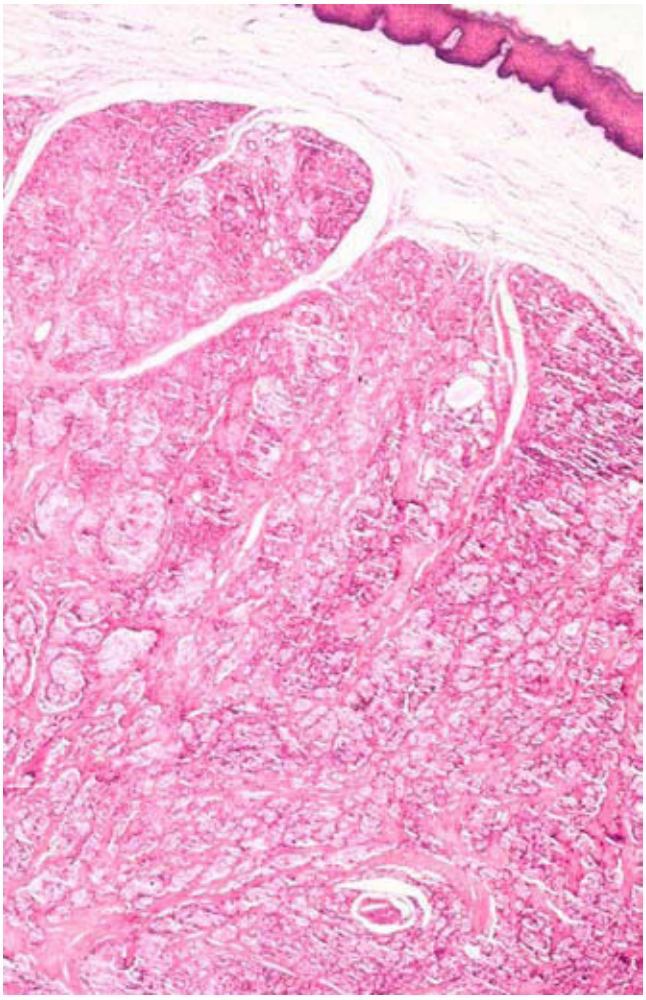

Figure 1 Multilobulated neoplasm composed of solid islets that infiltrate the deep tissues. The neoplasm is covered by intact mucosa and is adjacent to normal salivary glands (hematoxylin-eosin, original magnification ×40).

presence of neural invasion or necrosis, the number of mitoses per field, or the presence of anaplasia, are useful to define mucoepidermoid carcinoma as low, medium, or high grade (Table 1). The grading criteria correlate with the biological behavior of the tumor,[6] though the best prognostic indicator is the clinical stage.[7] Metastasis and recurrence are rare in low-grade or well-differentiated mucoepidermoid carcinoma. Conversely, up to 80% of high-grade mucoepidermoid carcinomas metastasize or cause death.[6] Although mucoepidermoid carcinoma of the oral cavity tends to be low grade, wide surgical resection is required to ensure disease-free margins. Postoperative radiotherapy is useful in high-grade carcinomas, particularly if the surgical margins are affected or the tumors show perineural or vascular invasion.[7,8] Chemotherapy may also be beneficial in high-grade carcinomas, and the use of epithelial growth factor inhibitors is currently being investigated.[8]

In the case we describe, wide excision was performed and disease-free margins were achieved; the radiologic studies showed no metastatic disease. The patient remains free of disease after 5 years of follow-up.

Although malignant tumors of the minor salivary glands of the lip are rare, their therapeutic and prognostic implications mean that they should be considered in the differential diagnosis of submucosal nodules of the lip.

Table 1 Grading of Mucoepidermoid Carcinomas[7]

Parameter	Points
Cystic component <20%	+2
Presence of neural invasion	+2
Presence of necrosis	+3
Mitoses (≥4 × per 10 high-power fields)	+3
Presence of anaplasia	+4

0-4, low grade; 5-6, medium grade; ≥7, high grade.

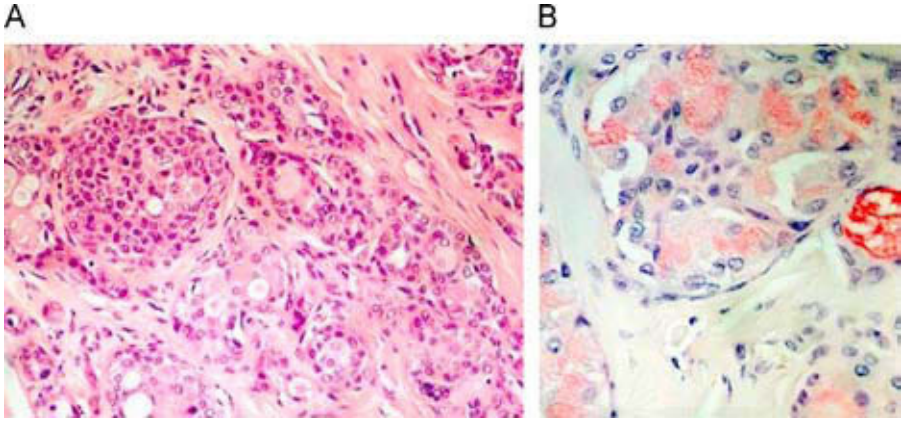

Figure 2 A, A mixed cell population is observed, with a predominance of nonkeratinizing squamous cells with abundant eosinophilic cytoplasm and intermediate cells. There are foci of clear and mucus-secreting cells with the formation of microcystic and ductal structures (hematoxylin-eosin, original magnification ×200). Tumor necrosis was not observed and the degree of atypia and the mitotic index were low, although perineural infiltration was identified. B, Detailed view of the mucus-secreting cells (mucicarmine, original magnification ×200).

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Primary Cutaneous CD30+ Large T-Cell Lymphoma with Lymph Node and Cerebral Metastases

Linfoma T de células grandes CD30+ cutáneo primario: presentación de un caso, con metástasis ganglionares y cerebral

To the Editor:

Lymphomas account for a small proportion of skin tumors. Primary cutaneous T-cell lymphoma (CTCL), specifically, accounts for just a small proportion of non-Hodgkin lymphomas, with an incidence of 0.36 cases per 100 000 population per year.[1]

CD30+ anaplastic large T-cell lymphoma (ALCL), a form of CTCL, is characterized by large atypical lymphocytes with an anaplastic, pleomorphic, or immunoblastic morphology and expression of the CD30 antigen by the majority (>75%) of tumor cells.[2] In the World Health Organization-European Organization for Research and Treatment of Cancer Classification of Cutaneous Lymphomas, ALCL is included in the subgroup of primary cutaneous CD30+ lymphoproliferative disorders within the larger group of T-cell and natural killer cell neoplasms.[3,4] It responds well to treatment and has a favorable prognosis, unlike the more aggressive primary nodal variant.[5,6]

We present a rare and aggressive variant of CD30+ ALCL in which metastasis to the brain during chemotherapy contributed to the death of the patient.

The patient, an 84-year-old woman, was seen for several violaceous cutaneous tumor lesions, some of which were ulcerated, on the right forearm and upper arm (Figure 1); the lesions had appeared 2 years earlier. The examination also revealed a considerably enlarged right axillary lymph node that was hard and fixed to the deep layers.

Biopsy showed a tumor occupying the full thickness of the dermis with destruction of the appendages and sparing of the epidermis (Figure 2). The tumor was formed of large atypical cells with marked nuclear pleomorphism, prominent nucleoli (many of which were multiple), and eosinophilic cytoplasm. The mitotic index was high, with as many as 4 mitoses per high-power field; many of the mitoses were atypical.

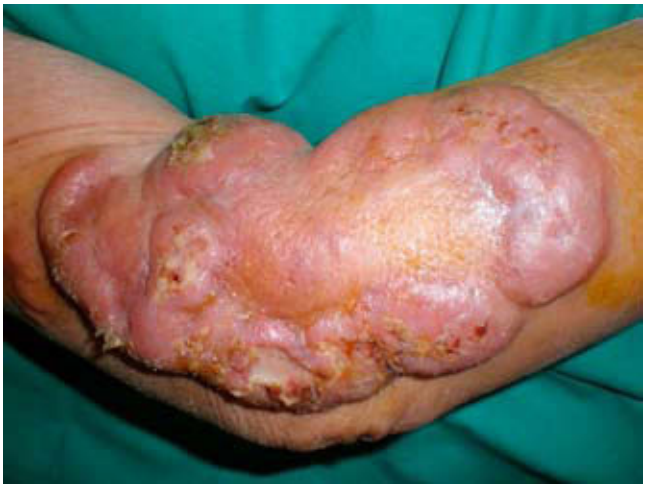

Figure 1 Erythematous-violaceous tumor lesion, with several ulcerated areas, occupying the lateral aspect of the right forearm and upper arm.