

Large Asymmetric Pigmented Nodule in a 27-Year-Old Female[☆]

Nódulo pigmentado asimétrico de gran tamaño en una mujer de 27 años

To the Editor:

A 27-year-old female presented with an asymptomatic nodule on the left thigh. She reported a smaller pigmented lesion since birth, with significant growth in the last 5 years. The patient had no personal or family history of skin cancer. She was otherwise healthy and had no systemic symptoms. She was doing oral contraception and no other medications.

Physical examination revealed a smooth nodular dome-shaped lesion measuring 1 cm × 2 cm, with central hyperpigmented and peripheral erythematous areas, located on the medium third of the anterior left thigh (Fig. 1). There was no regional lymphadenopathy.

Dermoscopically there was a central dark hyperpigmented area surrounded by a rim of thin regular pigment network (Fig. 2). In the central area we observed a predominant globular pattern, an eccentric thickened pigment network and a blue-whitish-veil.

Excision was performed. Histological examination revealed a compound (predominantly intradermal) melanocytic nevus with congenital-like growth pattern and a dermatofibroma, with no signs of malignancy (Fig. 3). Nevus cells involved deep dermal appendages and neurovascular structures and they became progressively smaller in deeper portions of the lesion suggesting maturation and benignity. Intermingled with melanocytes, there was a proliferation of spindle fibro-histiocytic cells characteristic of dermatofibroma.



Figure 1 Asymmetric pigmented nodule (1 cm × 2 cm) on the left anterior thigh.

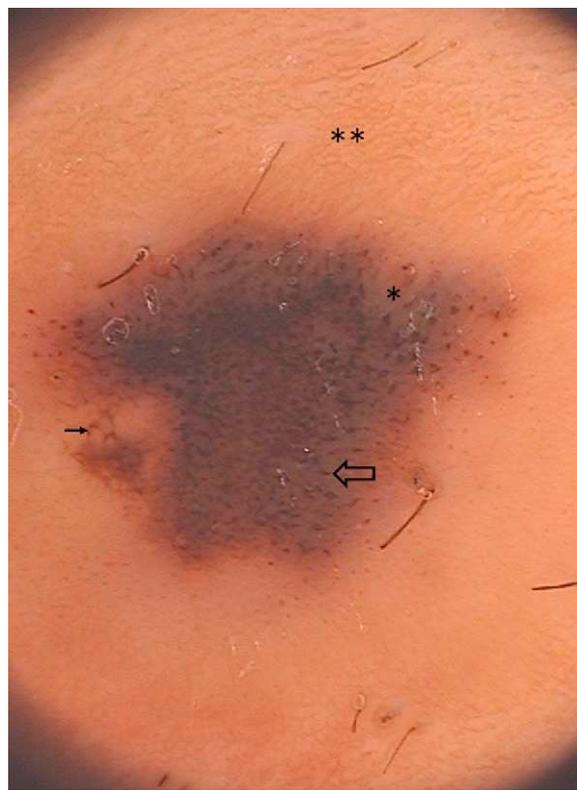


Figure 2 Dermoscopic picture (20×): central dark hyperpigmented area with a predominant globular pattern (thick arrow), an eccentric thickened pigment network (thin arrow) and a blue-whitish-veil (*), surrounded by a rim of thin regular pigment network (**).

Collision tumors result from the combination of two or more benign and/or malignant neoplasms in a single lesion.¹ As it is unknown whether the association is a random event or whether there is, in fact, a pathogenic relationship in the development of two distinctive neoplasms together, some authors propose the designation of compound tumor instead of collision tumor because the last one suggests the association is incidental.²

Collision tumors are not rare. Boyd and Rapini performed a retrospective evaluation of approximately 40,000 cuta-

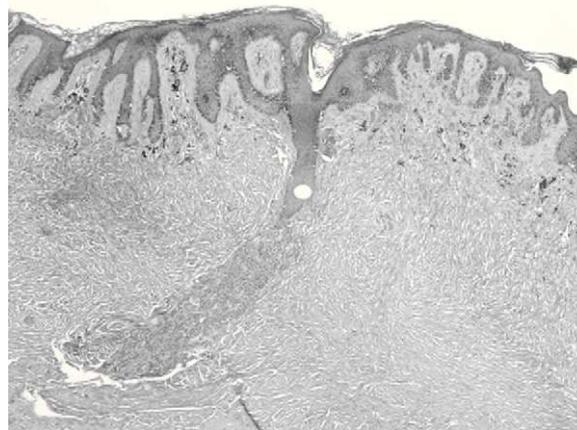


Figure 3 Histological picture (H&E, 4×): collision tumor of congenital nevus and dermatofibroma.

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neous biopsies, yielding 69 collision tumors.³ Cascajo and colleagues found 54 collision tumors of malignant cutaneous neoplasms associated with seborrheic keratoses in 85,000 biopsies.²

The most common combinations found by Boyd and Rapini included basal cell carcinoma and nevus (14), basal cell carcinoma and seborrheic keratosis (8), nevus and seborrheic keratosis (14), actinic keratosis and nevus (7), and basal cell carcinoma and neurofibroma (4).³ Another commonly described association is that of melanocytic nevus with desmoplastic trichoepithelioma.¹ Our patient had a compound tumor of congenital nevus and dermatofibroma. As far as we know, this is the first reported case of such a combination.

Furthermore this tumor clinically and dermoscopically mimicked malignant melanoma. Although in some cases dermoscopy can help with collision tumor diagnosis,⁴ this was not the case. In fact, according to Giorgi and colleagues cutaneous collision tumors are extremely difficult to diagnose preoperatively, even with the help of dermoscopy, in particular when one of the lesions is melanocytic.⁵ The presence of a pigment network, the pathognomonic sign of the melanocytic lesion, allows dermatologists to use dermoscopic algorithms, which in this case ended up in the wrong preoperative diagnosis of a malignant lesion.

References

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Acquired Generalized Hypertrichosis Due to Diazoxide[☆]

Hipertrichosis generalizada adquirida por diazóxido

To the Editor:

Hypertrichosis is defined as the excessive growth of hair on any part of the body.¹ In hirsutism, on the other hand, the hair follicles have different characteristics and an androgenic distribution. Clinically, hypertrichosis is classified according to its extension, as localized or generalized, and to its etiology, as congenital or acquired. The origin of acquired generalized hypertrichosis can be idiopathic, iatrogenic, or related to systemic diseases,² such as hypothyroidism, porphyria, celiac disease, dermatomyositis, human immunodeficiency virus (HIV) infection, or tumors. The widespread appearance of lanugo in the adult may be a sign of internal cancer or portend the onset of malignant disease; however, there have been no reports of such cases in children.³

We report the case of a 6-year-old boy who was referred to our outpatient clinic for the growth of terminal hair that had started to develop on the face, trunk, and limbs (Fig. 1) during his first year of life and had been slowly progressive. The patient had been diagnosed with hyperinsulinemic hypo-

glycemia of infancy at 5 months of age and was on treatment with diazoxide, 20 mg/kg/d, with adequate control. There was no family history of interest. He did not present growth retardation, neurological disturbances, or other typically relevant underlying diseases or treatments. Physical examination revealed widespread hypertrichosis, most marked on the forehead, upper lip, and eyebrows, which had started to develop some months after introduction of the full dose of diazoxide (Fig. 2). There was no predilection for sun-exposed areas. No other lesions were observed on the skin or mucosas and his teeth were normal. Blood tests including



Figure 1 Widespread increase of terminal hair on the trunk and upper limbs.

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