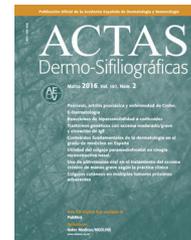




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CASE AND RESEARCH LETTERS

Dermoscopic Features of Spiradenocylindroma[☆]



Espiroadenocilindroma: hallazgos dermatoscópicos

To the Editor:

Benign cutaneous adnexal tumors are a heterogeneous group of uncommon lesions that includes spiradenoma and cylindroma. We report a case of coexisting spiradenoma and cylindroma and describe the corresponding dermoscopic findings.

A 37-year-old woman with no known medical history of interest was seen for an asymptomatic scalp lesion that was located on the hairline and had appeared 6 months earlier. Physical examination revealed a soft, rounded, skin-colored nodule (1 cm in diameter), upon which was a bluish, hard-elastic papule (Fig. 1).

Dermoscopy revealed a salmon-pink area containing linear vessels on the lesion surface and the presence at the lesion periphery of associated structures with homogeneous blue coloration. Yellowish-brown desquamation corresponding to seborrheic eczema was also observed (Fig. 1).

An excisional biopsy was performed. Subsequent histopathology revealed 2 distinct histological patterns. The first, more superficial pattern corresponded to a dermal tumor composed of multiple basophilic nodules formed by strands of dark basaloid cells and larger cells with pale nuclei. Ductal structures were also observed inside the lobes, as well as hyaline drops and squamous corpuscles (Fig. 2).

The second pattern, observed in the deepest part of the lesion, consisted of irregular strands of basophilic cells arranged in a checkerboard pattern and surrounded by eosinophilic hyaline bands (Fig. 2). Based on these findings a diagnosis of spiradenocylindroma was established.

Spiradenoma, first described by Kersting and Helwing in 1956,¹ is more frequent in females aged 15 to 35 years. The clinical presentation consists of a single, soft, bluish nodule of 1 cm to 2 cm in diameter that is painful on

palpation and is typically located on the trunk or neck.^{1,2} In 2015 Sahin³ reported the following dermoscopic features of this lesion: bluish pigmentation, varied vascular structures, and reticulated pigmentation at the lesion periphery. In the same year Ankad and coworkers⁴ described the trichoscopic features of spiradenoma, including the presence of red serpentine linear structures surrounded by whitish areas.

The term cylindroma was first used by Billroth in 1856 to describe a benign adnexal tumor that mainly affects women aged 20 to 30 years.^{5,6} Cylindroma presents as a firm, pink nodule located on the face or scalp, usually grows slowly, and has a mean size of 2 mm to 6 mm.⁷ Reported dermoscopic patterns include arboriform vessels on a whitish, salmon-pink background, blue dots and globules, and ulceration.^{8,9}

Spiradenoma and cylindroma are neoplasms of controversial histogenesis. Historically, spiradenoma has been considered a tumor of eccrine differentiation. However, its association with trichoepitheliomas in Brooke-Spiegler syndrome and with milium cysts in Rasmussen syndrome suggests a probable apocrine origin. Cylindroma was originally considered an apocrine tumor. Recent studies have revealed apocrine and eccrine characteristics in both tumor types. Some authors even claim that these tumors are derived from the follicular epithelium, since they are positive for CD200, an immunohistochemical marker of hair-follicle stem cells.^{5,10}

While co-occurrence of both neoplasms in the same patient has been previously reported, coexistence within the same clinical lesion is highly unusual. Meybehm and Fischer proposed the term spiradenocylindroma for this particular presentation.¹¹

Spiradenocylindroma presents as a benign tumor, which can be solitary or, in the case of Brooke-Spiegler syndrome, multiple. Physical examination of our patient, who had no family history of interest, revealed a solitary lesion and no other pathological findings.^{10,11}

The dermoscopic features of spiradenocylindroma have not been previously described. In our case, the main dermoscopic findings were areas with salmon-pink coloration, linear vessels, and the presence at the lesion periphery of structures with a homogeneous blue coloration (Table 1).

We have reported this case to share our finding of a very rare adnexal tumor and to describe the dermoscopic features of spiradenocylindroma.

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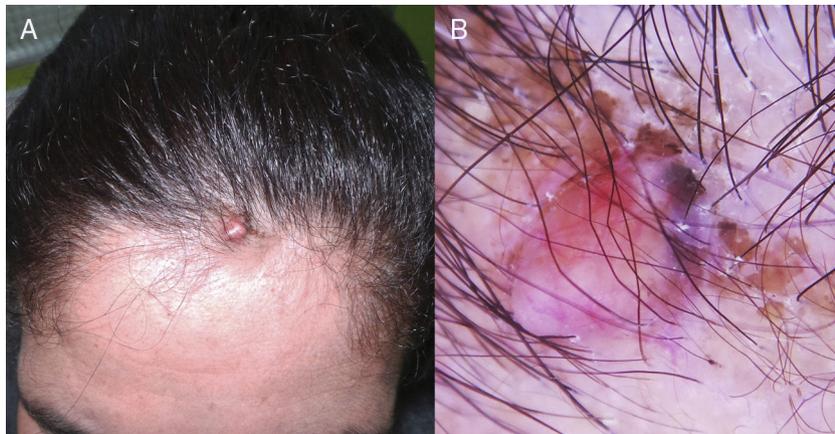


Figure 1 A, Skin-colored nodule on which a bluish papule is located. B, Dermoscopy showing a salmon-pink area, linear vessels, and homogeneous blue pigmentation.

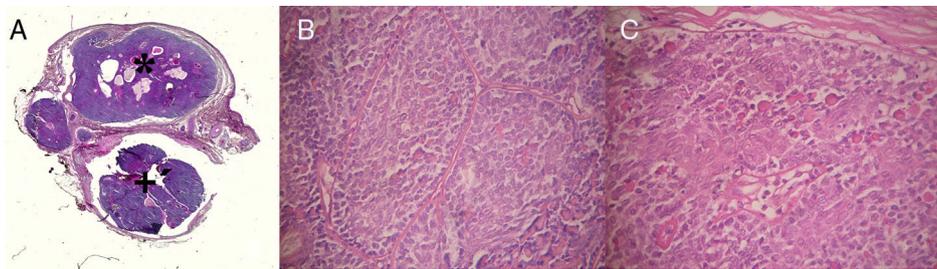


Figure 2 A, Spiradenoma (*) and cylindroma (+) within a single lesion (hematoxylin-eosin, original magnification $\times 40$). B, Spiradenoma: upper portion of the lesion consisting of cells with small hyperchromatic nuclei and others with large, pale nuclei (hematoxylin-eosin, original magnification $\times 400$). C, Cylindroma: lower portion of the lesion consisting of tumoral nests arranged in a checkerboard pattern and surrounded by hyaline bands (hematoxylin-eosin, original magnification $\times 400$).

Table 1 Differential Diagnosis of Spiradenoma, Cylindroma, and Spiradenocylindroma

	Spiradenoma	Cylindroma	Spiradenocylindroma
Age at presentation, y	15–35 ¹	20–30 ⁶	20–73 ¹²
Clinical appearance	Soft bluish nodule, painful on palpation, located on the trunk and neck. ^{1,2}	Firm, pink nodule located on the face or scalp. ⁷	Solitary or multiple lesions. Frequently associated with Brooke-Spiegler syndrome. ¹²
Histology	Nodules composed of 2 cell types: small hyperchromatic cells and other larger cells with pale nuclei and ductal differentiation. Thin basal membrane. Frequent lymphocytic infiltration. ¹⁰	Small lobules of basaloid cells arranged in a checkerboard pattern and surrounded by a prominent hyaline basement membrane. Positive periodic acid-Schiff staining. Absence of inflammatory infiltrate. ¹⁰	Two distinct histological patterns within the same lesion. ¹⁰
Dermoscopic features	Light blue pigment with peripheral reticulate pigmentation, associated with reddish linear serpentine structures surrounded by whitish areas. ^{3,4}	Blue dots and globules associated with arboriform vessels on a whitish, salmon-pink background. ^{8,9}	Salmon-pink areas, linear vessels, and peripheral structures with homogeneous blue pigmentation.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Acknowledgments

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Absolute Versus Relative Psoriasis Area and Severity Index in Clinical Practice[☆]



PASI absoluto versus PASI relativo en la práctica clínica real

To the Editor:

Since the introduction of biological drugs, a 75% reduction in the psoriasis area and severity index score (PASI 75) relative to baseline values has been the primary measure used in most clinical trials.^{1–4} With the emergence of new, high-efficacy interleukin-17 inhibitors,^{3,4} the use of PASI 90 and PASI 100 has become more frequent. However, in routine clinical practice absolute PASI is much more commonly used to quantify treatment effectiveness.

The main objective of this study was to compare absolute PASI score with the relative reduction in PASI in patients treated with etanercept (ETN), adalimumab (ADA), and ustekinumab (UST). In addition, we evaluated the long-term clinical effectiveness of each biological treatment. This was an observational, retrospective, single-center study of adult

patients with moderate-to-severe plaque psoriasis who were treated with biological drugs for at least 1 year between June 2005 and May 2017. Although no exclusion criteria were specified when designing the study, patients treated with infliximab were excluded owing to the small sample size (n = 4). Demographic characteristics and clinical data were recorded at the beginning of the last biological treatment (Table 1 Table 2). Where relevant, reasons for treatment discontinuation were also recorded.

Statistical analyses were performed with the SPSS® statistical package version 21 for Windows (SPSS Inc, Chicago, Illinois, USA) and statistical significance set at 0.05. A data-as-observed approach was applied (i.e., no substitution methods were applied in cases of missing data).

The study population consisted of 157 patients, of whom 23 (14.6%) were treated with ETN, 38 (24.2%) with ADA, and 96 (61.1%) with UST. Table 1 shows the baseline characteristics of the study population. There were no significant differences in PASI variables between groups at baseline.

The percentage of patients who achieved PASI 75, PASI 90, PASI ≤5, and PASI ≤3 after 1, 3, and 5 years of treatment is shown in Figure 1. Analysis of the combined study population and of each treatment group revealed that for the 3 timepoints studied a non-negligible percentage of patients who did not achieve PASI 90 did achieve PASI ≤5 or PASI ≤3 (Table 3). Of the patients who did not achieve PASI 90 after 1 year of treatment, 68.4% achieved PASI ≤5 and 40.8% achieved PASI ≤3. The corresponding comparisons after 3

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