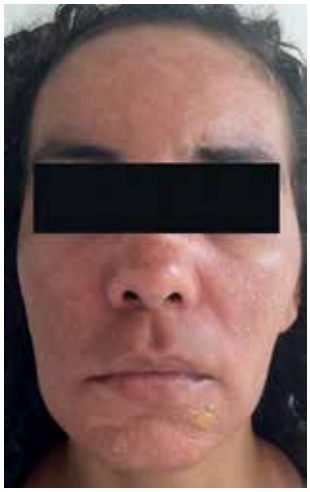

Figure 1: Accentuated face swelling and erythema

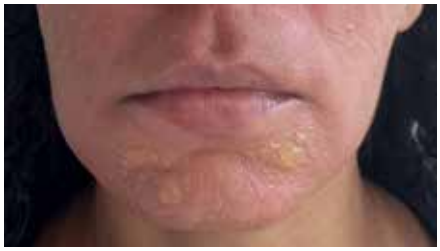

Figure 2: Details of vesicles and blisters in the chin area

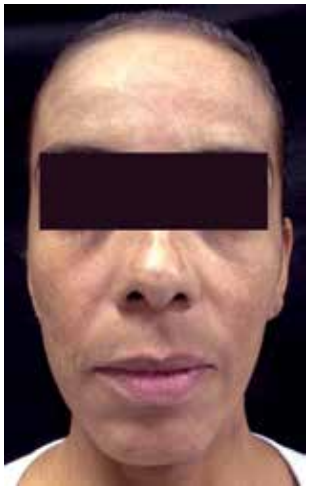

Figure 3: Full improvement of the unexpected reaction to tretinoin peeling

standard tray including cosmetics) and, at the 96-hour reading, it was positive for thimerosol (1+) and nickel sulfate (1+). Tretinoin was tested at 0.005% and 0.01% in an alcohol solution and 0.05% in vaseline. The test was positive for the 0.05% concentration only, with a reaction intensity of 1+ in both readings: at 48 and at 96 hours.

The occurrence of a high intensity and a rapid onset of a dermatitis condition, with the formation of vesicles and blisters after the tretinoin peeling is still a relatively unknown event. No similar case has been reported in prior literature. Standardization of tretinoin patch testings is defective due to the irritating nature of retinoic acid. Different tretinoin concentrations were used in some case reports.[4,5] Despite its exuberance, the onset of this condition took place before 24 hours after the peeling application, and tretinoin positivity was only observed at the highest concentration, which maintained the same intensity of 1+ at the 48- and 96-hour readings, which suggests irritant contact dermatitis. Patient has been under dermatology follow-up, using topical medications, and submitted to salicylic acid peeling at 30%, without intercurrent events. Despite the intense adverse reaction, patient progressed to full recovery. ❑

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Inflammatory mixo-hyaline tumor of distal extremities - a rare sarcoma simulating benign diseases*

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Dear Editor,

We present here a case of inflammatory mixo-hyaline tumor, a low degree sarcoma that, due to its rarity and because it has a broad differential diagnosis, tends to be frequently confused with benign diseases. In addition, the diagnosis is complex due to the peculiar histopathological characteristics of this sarcoma. A surface biopsy can lead to errors in the diagnosis resulting from confusion with mixoid benign tumors or inflammatory diseases.[1,2]

A female patient, 61 years of age, had been undergoing follow-up for palmoplantar psoriasis since 55 years of age. Three years ago, in a routine doctor's appointment, she complained of a painless bulge and important dystrophy of the fingernail of the third left finger, whose histopathological result of the incisional biopsy revealed a mesenchymal proliferation comprised of fusiform cells with pleomorphic areas, suggestive of pleomorphic fibroma. The lesion was excised. Two years ago, the patient again reported a bulge in the distal phalange involving the proximal fingernail of the same finger. The patient underwent a new excision of the lesion, and the histopathological result was compatible with a hybrid cyst (epidermal and trichilemmal). In March 2015, she came to her follow-up appointment presenting a friable erythematous nodule on the side of the fingernail of approximately 2 cm. Also observed were a bulge in the distal phalange and marked dystrophy of the fingernail (Figure 1). A new incisional biopsy was performed, whose histopathological findings were compatible with inflammatory mixo-hyaline sarcoma, which was also confirmed by immune-histochemical analysis (Figures 2 and 3). The patient was referred to the oncology service to carry out a more in-depth surgical approach.

Inflammatory mixo-hyaline of the distal extremities, also known as acral mixo-inflammatory fibroblastic sarcoma, is a low-degree sarcoma that is extremely rare, first described by Montgomery in 1997. This sarcoma has a tendency for local recurrence, especially when only partially excised, through it possesses a low metastatic potential. It occurs primarily in adults and appears as a painless mass in the distal region of the limbs. The upper limbs are more affected than the lower limbs, with the fingers and hands being the most commonly affected. The clinical diagnosis of this tumor before biopsy is generally that of an inflammatory benign lesion (60% of the cases), and its differential diagnosis is performed with reactive processes and neoplasias, such as mixo-fibrosarcoma, epithelioid sarcoma, Hodgkin's disease, and superficial acral fibromyxoma.[1-3] In the reported case, the tumor appeared as a painless bulge and dystrophy of the fingernail. After two apparently macroscopically complete excisions, a new local recurrence appeared and was submitted to an incisional biopsy. Histologically speaking, the sarcoma of the distal extremities appears in three main types of tumor cells. The first type is similar to virocytes or to Reed-Sternberg cells; the second typed contains multivacuolated cells imitating pleomorphic lipoblasts; and the third type contains gigantic cells with characteristics of emperipolesis.[3,4] Under histochemical staining, these tumors express vimentin and can have a CD68 focal coloration.[4] In our case report, in the incisional sample, binucleated cells could be observed with evident nucleolus, similar to Reed-Sternberg cells surrounded by either a mixoid or a fibrous matrix and with permeable blood vessels (Figures 2 and 3). Immunohistochemical analysis was focally positive for actin of the smooth muscle and negative for Alk-1, cytokeratins, S-100, S-100 protein, human melanoma black-45 (HMB-45), and Melan-A. The rarity and broad variety of the morphologies make it important to understand the inflammatory mixo-hyaline

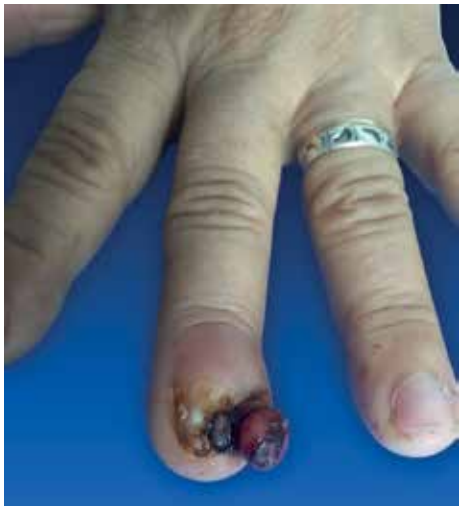

Figure 1: Friable erythematous nodule in lateral fingernail, bulge of distal phalange and marked dystrophy of the fingernail

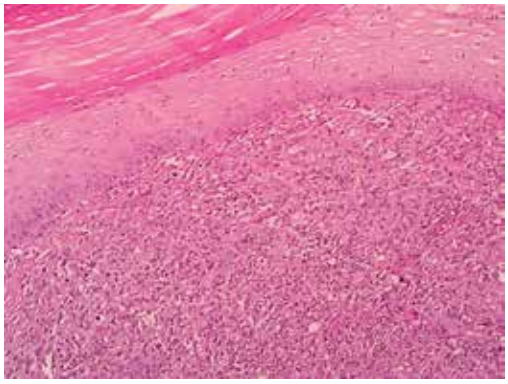

Figure 2: HE – Magnification of 200x: Proliferation of mesenchymal, pleomorphic cells, dispersed throughout the dermis and infiltrate. Mixed inflammatory

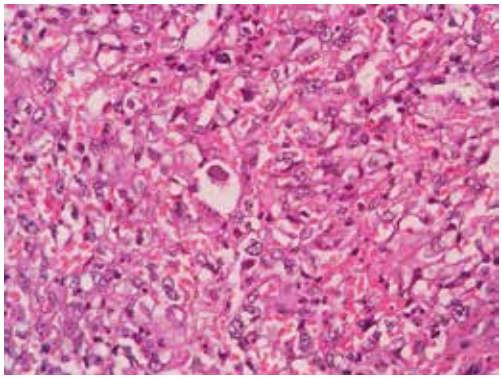

Figure 3: HE – Magnification of 400x: Atypical neoplastic cells, with thin cytoplasm, large nuclei with open chromatin and evident nucleolus, some surrounded with halos and forming structures that have an appearance similar to virocytes or Reed-Sternberg cells. Dense inflammatory infiltrate consisting of lymphocytes and neutrophils

tumor, a low-degree sarcoma that can simulate more aggressive sarcomas or imitate an inflammatory process through an extreme scarcity or clear absence of characteristic lesional cells. However, regardless of the histological findings, a complete excision, preferably with free margins, is the most efficient approach to reduce the incidence of the local recurrence of the disease, which is the main cause of morbidity associated with the tumor. In addition, adjuvant therapy, such as radiation, can be considered for those patients with positive surgical margins, especially if the tumor contains atypical histological characteristics.[1,3,5] ❑

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Multiple adult-onset xanthogranuloma, an uncommon diagnosis*

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Dear Editor,

A 77-year-old Caucasian male patient was referred to our Service for presenting brownish and erythematous-violet papules (4 to 8 mm), located bilaterally in arms, armpits, lower abdominal quadrants and thighs (Figure 1). There was no involvement of the face, dorsal surface of the joints or mucous membranes. The lesions, which were always asymptomatic, had evolved progressively for ten months.

At the general objective examination, there were no significant alterations, namely ophthalmologic, cardiopulmonary and neurological. No systemic semiology or relevant family history coexisted. Among the patient's personal antecedents were major depression and anxiety disorder. Diagnoses of histiocytosis, particularly generalized eruptive histiocytoma, multiple adult xanthogranuloma (XGA), Erdheim-Chester disease and cutaneous metastases, were considered.

The histopathological study of a lesion showed infiltration of the dermis and, in particular, of the hypodermis by histiocytes with foamy cytoplasm, accompanied by Touton cells, occasional lymphocytes and rare eosinophils (Figure 2). Infiltrate cells were CD68 positive and protein S100 and CD1a negative (Figure 3).

No alterations were observed in the complementary evaluation, which included: hemogram with leukogram; blood biochemistry; electrophoretic proteinogram and serum immunofixation; urinalysis, diuresis monitoring and pituitary hormone study; skeletal radiography; electrocardiogram; respiratory function tests; cranioenchephalic and thoraco-abdominopelvic tomodensitometry studies.

Figure 1: Adult multiple xanthogranuloma. **A.** Detail of papule-nodular, brown and erythematous-violaceous lesions, asymptomatic, in the right arm. **B**. Detail of lesions on the right thigh

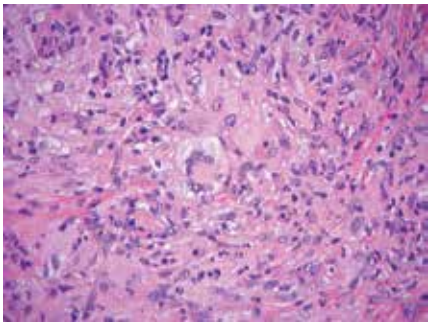

Figure 2: Histopathology - hematoxylin-eosin, original magnification 400x. Infiltration of the entire thickness of the dermis by histiocytes with foamy cytoplasm, accompanied by multinucleated Touton giant cells