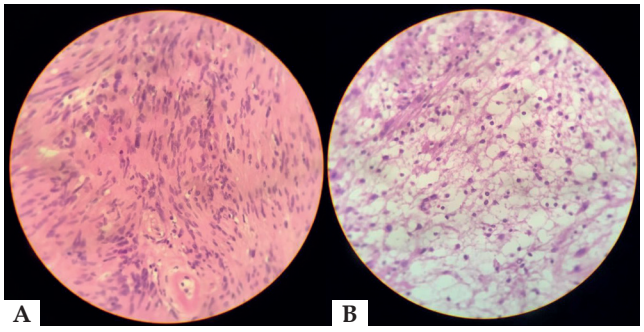

Figure 3: A. Microscopic examination: Lesion predominantly composed of fusiform cells. Antoni type A is a highly ordered cellular pattern in which spindle cells are arranged in compact fascicles and their nuclei are arranged in palisades (Hematoxylin & eosin x 400). **B.** Antoni type B tissue is less cellular with pale zones of gelatinous matrix (Hematoxylin & eosin x400)

The etiopathogenesis of CS is unknown, but they sometimes occur in people with certain disorders including some types of neurofibromatosis.[2] CS are generally asymptomatic, however, when pain is present, it is usually associated with compression the adjacent structures of nerve and the paresthesias restricted on the tumor site or radiating along nerve of origin. . CS most often occurs in the 4th and 5th decades of life, without significant evidence of sex predilection.[3] Histopathologically, CSs are typically encapsulated by perineurium and are characterized by two types of histological patterns: Antoni type A and Antoni type B. Antoni A is a highly ordered cellular pattern in which spindle cells are arranged in compact fascicles and their nuclei are arranged in palisades. Verocay bodies are a characteristic feature in Antoni type A pattern, with collagen matrix arranged into palisading.. Antoni type B tissue exhibits a looser structure of mucinous matrix and it´s less cellular.[3]

The differential diagnosis of CS includes proliferating pilomatricoma, epithelial cysts, lipoma, desmoid tumor, and rheumatoid nodule.[1-5] Although some tumors of the skin are difficult to diagnose, if they are painful, nine tumors should be considered: **l**eiomyoma, **e**ccrine spiradenoma, **n**euroma, **d**ermatofibroma, **a**ngiolipoma, **n**eurilemmoma, **e**ndometrioma, **g**lomus tumor, and **g**ranular cell tumor (LEND AN EGG).

The best treatment option is local excision.[1-4] Sonographic images may offer detailed information about the tumor location and its relationship to the vessel.[4] In our case, we detected no vascular flow or signs of central vascularization, which led to successful tumor excision.

Studies indicate that CS can be removed by delicate enucleation with an acceptable risk of injury to the nerve trunk.[3] In our case, we performed complete surgical resection of the tumor. Six months later, the patient was able to walk without assistance and without pain. He complained of discrete paresthesia.

Although this tumor may be considered common, the large size and leg location we report herein are infrequently described in the literature. More often, they are recognizable head and neck tumors that range in size from 0.25-3.00cm.[1-3] ❑

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A case of unilateral blaschkoid lichen planus pigmentosus*

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Dear Editor,

Lichen planus pigmentosus (LPP) is a rare variant of lichen planus.[1] A few cases of LPP involving linear, blaschkoid, and zosteriform patterns have been reported in the literature.[2-4] We herein describe a case involving a 48-year-old female patient with unilateral abdominal involvement of LPP following the lines of Blaschko.

A 48-year-old female patient was admitted to our clinic with a 2-year history of a pruritic rash localized to the right half of the abdomen. The patient's medical history revealed that she had been using levetiracetam and levothyroxine for 8 years to treat epilepsy

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and hypothyroidism. On dermatologic examination, livid-brown, S-shaped, and linear-patterned macules and papules were observed from the right half of her abdomen to the right lumbar area with a tendency to coalescence (Figure 1). Mucous membranes, scalp, and nails were not affected. The results of routine laboratory tests were all within normal limits. Histopathological examination of a punch biopsy specimen from the lesions revealed hyperkeratosis, epithelial atrophy, hydropic degeneration in the basal layer, civatte bodies, band-like lymphocytic infiltrates, and pigment incontinence in the papillary dermis (Figure 2). A diagnosis of unilateral blaschkoid LPP was made based on the clinical and histopathological evaluations.

LPP is differentiated from classic lichen planus. In contrast to the shiny, purplish papules and plaques seen in classic lichen planus, LPP is characterized by dark brown-gray macules, patches, and occasionally papules. Furthermore, the mucosa, scalp, and nails, which are the sites at which lichen planus is frequently localized, are generally not involved in LPP. Although the histopathological findings are similar, melanin incontinence is more prominent in LPP than in classic lichen planus. It is also differentiated from zosteriform LPP by the absence of dermatomal involvement.[1,2] LPP tends to be localized in sun-exposed areas, such as the head and neck, as well as in flexor areas, such as the axillary, inguinal, and submammary regions. However, only a few cases of LPP involving Blaschko's lines have been reported.[2-4]

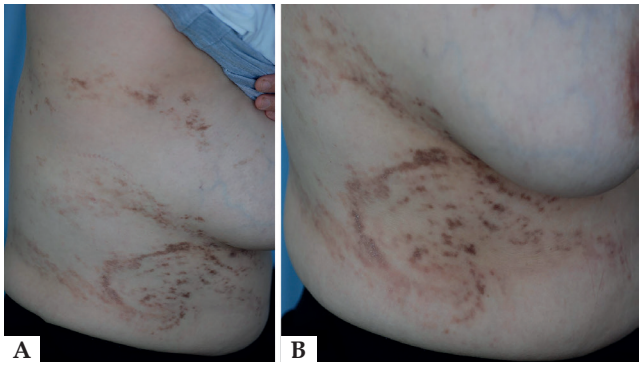

Figure 1: A. Livid-brown, S-shaped, and linear-patterned macules and papules. **B.** Close-up of the lesion

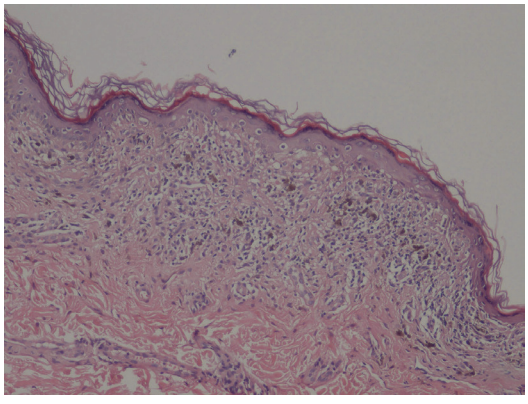

Figure 2: Hyperkeratosis, epithelial atrophy, hydropic degeneration in the basal layer, civatte bodies, band-like lymphocytic infiltrates, and pigment incontinence in the papillary dermis (Hematoxylin & eosin X10)

In 2004, Hong *et al.* were the first to report two cases of LPP that presented as unilateral LPP with a linear pattern: one was localized on the leg and the other on the arm.[5] Seo *et al.* later reported another case of linear LPP involving a 60-year-old male patient with a history of gastric cancer who developed unilateral involvement on his neck and chin.[1]

Akarsu *et al.* were the first to report a case of LPP with unilateral Blaschkoid involvement of the trunk.[2] A 16-year-old female patient developed lesions in her submammary and pectoral areas. She had no history of drug intake, sun exposure, or trauma, and she did not exhibit mucosa or nail involvement. Dossi Cataldo *et al.* reported a second case with LPP with Blaschkoid distribution in a patient with three clinical subtypes.[4] Vineet *et al.* presented a third case of LPP with lesions lateralized to the right side of the body along the lines of Blaschko in a linear and zosteriform pattern.[3]

The present report describes the fourth case of LPP on the trunk following the lines of Blaschko. The patient had been using levetiracetam and levothyroxine for 8 years to treat epilepsy and hypothyroidism. However, we did not consider that the LPP had been induced by these medications or by the concomitant diseases because of the prolonged history and histopathological findings. Additionally, our patient did not have nail or mucosa involvement, similar to the other cases reported.[2-4]

Blaschkoid LPP may be confused with erythema dyschromicum perstans, linear and whorled nevoid hypermelanosis, incontinentia pigmenti, actinic lichen planus, lichen striatus, and Riehl's melanosis. Because clinical differentiation is not always possible, histopathological assessment is recommended.[2]

This case was deemed worthy of presentation because of the rarity of the condition and the fact that this is the fourth reported case of blaschkoid LPP localized on the trunk. ❑

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