Verrucous Hemangioma

Sir,

Verrucous hemangioma (VH) is characterized by hemangioma from the dermis to the subcutaneous tissue and proliferative reaction of the epidermis. This is sometimes confused with angiokeratoma circumscriptum neviforme (ACN), but it is considered that hemangioma of angiokeratoma is located in the dermal papilla, whereas VH extends into the subcutis. Here we report a case of VH, clinically resembling verruca vulgaris and malignant melanoma.

CASE REPORT

An 8-year-old Japanese boy visited our department in April 1991, complaining of a black tumor on his right 3rd toe. The tumor had existed for more than 6 months, and had once been treated as a verruca vulgaris in another clinic, but it had rapidly recurred and was gradually increasing in size. When the patient came to our hospital, the tumor was bluish, 1.2 cm and 0.6 cm in diameter and height, respectively (Fig. 1). The surface was hyperkeratotic and hemorrhaged. Irregularly shaped pigmentation was also seen. No regional lymph nodes were palpable, and physical examination revealed no significant abnormalities. At this point, we diagnosed it as a verruca vulgaris, but the possibility of malignant melanoma was considered, since the tumor had quickly enlarged and was resistant to normal therapy such as cryosurgery. It was then decided that the boy was to be operated under the condition of total anesthesia.

Histological examination showed marked hyperkeratosis, acanthosis in the epidermis, and elongation of the rete ridges. In the dermis, a lot of lumen structures with endothelial cells were seen from the dermal papilla to the lower dermis, which contained many red blood cells. The lumina were also observed in the subcutaneous fat tissues (Fig. 2). The endothelial cells were positively stained by factor VIII related antigen using peroxidase-antiperoxidase technique (data not shown). Thus, these structures were considered dilated blood vessels. No atypical or malignant cells were seen in any of the sections. From these findings, we finally diagnosed this tumor as a verrucous hemangioma. The patient has been followed up without any other treatment; no evidence of recurrence has been found after the operation so far.

DISCUSSION

VH was firstly reported by Imperial & Helwig in 1967 (1). It presents as a single patch, sometimes with surrounding satellite lesions, and is mainly located on the inferior limbs. Clinical onset is usually near the time of birth or in early infancy. It is histologically characterized by vascular dilatation and proliferation, which extends deep into the dermis and subcutaneous tissue. The overlying epidermis shows papillomatosis, acanthosis and hyperkeratosis of various degrees.

In 1990, Hamanaka et al. (2) summarized 21 Japanese cases. They mentioned in their report that the age of the patients ranged from 9 months to 53 years, with an average of 19 years. Most of the tumors were located on the lower limbs, with some exceptions: two on the flank, two on the forearm, and one in the inguinal region. These findings in Japanese cases are consistent with the description in textbooks.

VH is usually compared with ACN. Generally, VH is present at birth as a single nodule with satellite lesions, while ACN appears in infancy as small dotted elements.

It is sometimes difficult to distinguish VH from ACN, because of the similarity of the clinical and even the pathological features. But Rossi et al. (3) indicated that ACN was a hemangioma in the dermal papilla; VH, on the other hand, was present from the deep dermis to the subcutis. It is, therefore, important whether the hemangioma is present in the subcutaneous tissue for the diagnosis of VH. Since the hemangiomatous lesion of VH lies deep into the subcutis, it is sometimes recurrent despite surgical operation. It is important to differentiate this disease from angiokeratoma, for the prognostic implication.

REFERENCES


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"Clown Nose" as a First Manifestation of Lung Carcinoma

Sir,

Lung carcinoma is responsible for the majority of skin metastases in men and is second only to breast cancer as source of skin metastases in women (1, 2). There is a broad variety of clinical features, including nodules, papules, ulcers, inflammatory and sclerotic lesions, as well as lesions with a vesicular pattern (1). We report the case of a 58-year-old man with cutaneous metastasis located on the tip of the nose ("clown nose") from a previously undiagnosed lung carcinoma.

A 58-year-old man was examined for a rapidly growing nodule on the tip of the nose, which had developed 1 month earlier. The lesion was red-yellowish, dome-shaped, partially ulcerated and measured 2.5 cm in diameter (Fig. 1). The patient was otherwise asymptomatic. Histologic examination showed a dense infiltrate located in the entire dermis, composed of neoplastic cells with pleomorphic nuclei, one or more nucleoli and abundant, eosinophilic cytoplasm. Some cells were arranged in cords and isles, whereas others were distributed in glandular-like structures, separated by thin fibrous bundles (Fig. 2). Immunohistochemical studies, performed with a standard three-step immunoperoxidase technique on routinely fixed, paraffin-embedded tissue sections, showed reactivity of neoplastic cells for pan-cytokeratins, carcinoembryonic antigen and epithelial membrane antigen. Negative staining was observed with S-100, HMB-45 and leukocyte common antigen. Routine laboratory investigations showed moderate sideropenic anaemia and an erythrocyte sedimentation rate of 80 mm/h. A chest X-ray detected a nodular lesion in the left upper lobe of the lung, and a computed tomographic scan with contrast revealed the presence of an ipodense mass, consistent with a diagnosis of lung cancer. However, no signs or symptoms related to the primary tumour were present in our patient. The past history was remarkable for smoking 20 cigarettes a day but not for professional hazards. Based on clinicopathologic findings, the diagnosis of cutaneous metastasis from lung carcinoma was made. The patient died of widespread disease 3 months after the onset of the nasal lesion. Autopsy was not performed.

Lung cancers frequently metastasize to the anterior chest wall, abdomen, back, face and scalp, in decreasing order (1, 2). The "clown nose" manifestation, as observed in our patient, has been rarely described (3, 4). In the reported cases, the cutaneous lesion developed after the diagnosis of the visceral malignancy. In contrast, in our patient, the metastatic

Fig. 1. Nodular metastatic lesion on the tip of the nose from lung carcinoma.

Fig. 2. Dense infiltrate of neoplastic cells located in the entire dermis. Some cells were arranged in cords and isles, whereas others were distributed in glandular-like structures (hematoxylin-eosin stain; original magnification × 250).