LETTERS TO THE EDITOR

Angioendothelioma of the Nose

Sir,

Dr Waersted and colleagues recently described an elderly patient with an angioendotheliosarcoma of the nose. This was treated by radiotherapy alone with marked regression during an observation period of six months (1).

In 1974 we saw a very similar case. A 79-year-old man presented with a four-month history of swelling and redness on the left side of his nose and cheek. The skin was indurated and erythematous with ill-defined borders. There was no nodule formation. A biopsy showed a well differentiated angioendothelioma in the upper and mid-dermis. The endothelial cells were variable in shape and size and some possessed atypical hyperchromatic nuclei (Fig. 1). The case was reviewed by Professor E. Wilson Jones and included in his series of malignant vascular tumours reported in 1976 (2).

The patient refused any treatment. To our surprise the tumour gradually resolved spontaneously and one year later the skin was entirely normal. He died of unrelated causes eight years after presentation without any evidence of recurrence.

The prognosis of angiosarcoma of the face and scalp is generally poor. Radiotherapy may have a palliative effect, but rarely induces a long lasting regression (2). Patients are treated aggressively, so spontaneous regression is not noted.

Dr Waersted commented that radiation therapy alone may be a good choice of treatment in elderly patients. However, it is possible that tumours which show a long lasting "response" to radiotherapy have in fact undergone a spontaneous regression.

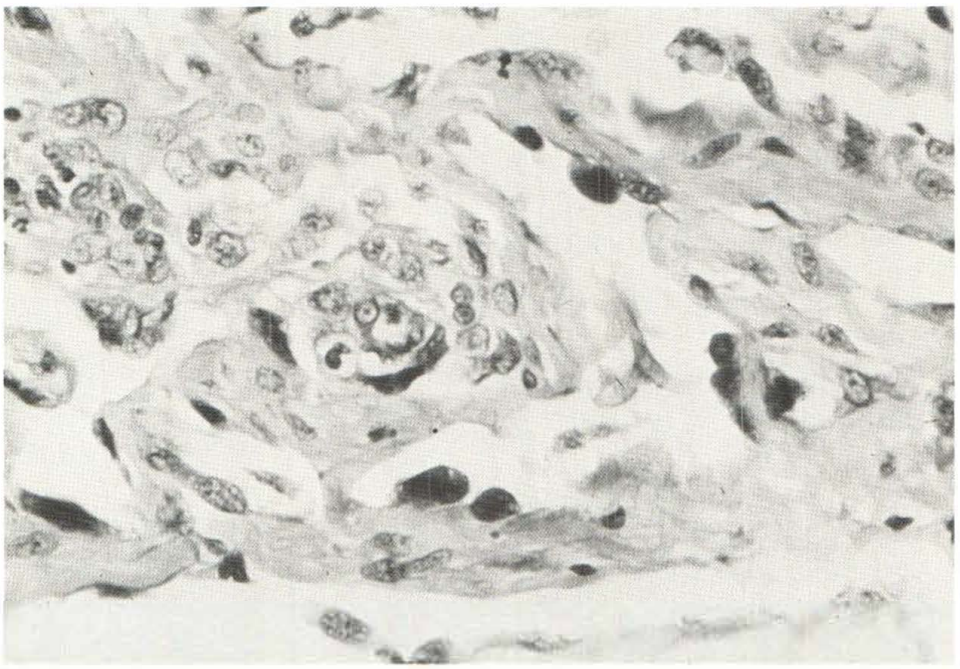

Fig. 1. Irregular dilated anastomosing channels with atypical endothelial cells and irregular intraluminal projections.

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Lichen planus and the Liver

Sir,

We read with great interest the short report by Mobacken et al. (1) denying the high prevalence of liver disease we found in lichen planus (LP) (2, 3).

Even though definitely lower than ours, their figures (2% of primary biliary cirrhosis and 2% of cryptogenic cirrhosis) are much higher than expected in the population at large. We do not have figures for Sweden, but in Northern Europe chronic hepatitis/liver cirrhosis accounts for 0.13–0.14% of population (4).

In any case, their lower percentage may depend on their different procedure of investigation. In fact, we re-investigated patients in whom the diagnosis of LP had been made years before and found that active chronic hepatitis (CAH) (not advanced cirrhosis) had developed in time periods ranging between 8 to 180 months from the LP diagnosis. Mobacken et al., by contrast, studied the *actual* condition of freshly diagnosed LP patients. We do not know what will happen to their patients in the future, especially beacuse the nature of the "minor aberrations" in the liver tests of 4 of them was not seriously investigated.

It is easier (and better) to diagnose CAH by liver biopsy in early stages, which are often marked by "minor aberrations" of liver tests, than in later stages when a "cryptogenic cirrhosis" has already developed.

Possibly due to the high prevalence of HBV infection in Italy, there was in our LP patients higher probability to develop CAH than in LP patients in Northern Europe where, for genetic reasons perhaps, primary biliary cirrhosis is more frequent.

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