NON-CLASSICAL KAPOSI'S SARCOMA IN A 53 YEAR-OLD HIV-NEGATIVE MAN

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Abstract: Kaposi's sarcoma (KS) is an angioproliferative disorder associated with human herpes virus 8 (HHV-8) that is clinically classified as either African endemic, AIDS-related epidemic, iatrogenic, or classic Mediterranean. Common risk factors for KS are HIV-positivity, immunodeficiency, or inhabitation within endemic areas. Here we present a case of 53 year-old immunocompetent HIV-negative African-American man who presents with red-brown annular plaques primarily on the lower extremities. Skin biopsies stained positive for CD34 and HHV-8 with histopathological features of KS. Our case is atypical in that it does not fit into the current classification scheme for KS.

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DOCETAXEL-INDUCED SCLERODERMA-LIKE LESIONS IN A PATIENT WITH PREEXISTING CREST SYNDROME

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Abstract: The taxanes – docetaxel and paclitaxel – are microtubule stabilizing chemotherapeutic agents that have demonstrated antineoplastic effects in a variety of solid tumors. Additionally, they have been linked to the development of cutaneous sclerosis in some patients. The taxanes cause skin sclerosis by way of the same mechanism that explains their cytotoxic efficacy: an increase in expression of certain inflammatory cytokines, including tumor necrosis factor-α, interleukin-2, interleukin-6, and interferon, γ. This immunologic milieu is reminiscent of that seen in naturally occurring scleroderma. We present a case of docetaxel-induced cutaneous sclerosis of the lower extremities in a patient with pre-existing CREST (calcinosis cutis, Raynaud's phenomenon, esophageal dysmotility, sclerodactyly, and telangiectasia) syndrome. To our knowledge, this is the first reported case in a patient with a prior history of limited scleroderma. We propose that a history of scleroderma, limited or diffuse, should be considered a relative contraindication to use of the taxanes.

ISOLATED FACIAL LIPOATROPHY IN A 7-YEAR-OLD GIRL

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A 7-year-old girl presented with isolated facial lipoatrophy for 11 months. Her parents first noticed decreased facial fullness 6 months after starting fludrocortisone 0.1 mg PO daily for hypotension in the setting of recurrent neurocardiogenic syncope. Physical examination revealed diffuse, symmetrical loss of the subcutaneous fat of the face. The etiology our patient's lipoatrophy may be due to acquired partial lipodystrophy or may be fludrocortisone-associated. Low levels of complement 3 were observed in our case patient, which can be a finding in acquired partial lipodystrophy. To our knowledge, only one report exists of localized lipoatrophy associated with systemic corticosteroid administration.

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ERYTHRODERMIC VERRUCOUS PSORIASIS

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A 46-year-old African American male was referred to our clinic with an 8-year history of extensive malodorous, symmetric verrucous plaques manifesting as erythroderma. Exam was also significant for ectropion and nail dystrophy. Biopsies showed epidermal hyperplasia and papillomatosis, parakeratosis with neutrophils, and dilated vessels in the dermal papillae. PCR of lesional skin was negative for HPV DNA. A workup for underlying immunodeficiency was negative. The patient had no accompanying systemic complaints and no previous dermatologic disease. Differential diagnoses included verrucous carcinoma, acquired ichthyosis, verrucous psoriasis, and Darier disease. The patient was diagnosed with erythrodermic verrucous psoriasis (VP). VP is a rare presentation of psoriasis and has only been reported as a localized variant. To our knowledge erythrodermic VP has not been reported. VP is characterized clinically by symmetric hypertrophic verrucous plaques on an erythematous base and histologically by overlapping features of both verruca and psoriasis with negative HPV studies. This presentation was a diagnostic and therapeutic challenge and serves to heighten the awareness of a unique variant of psoriasis.

ERYTHEMA MULTIFORME-LIKE BULLOUS PEMPHIGOID ASSOCIATED WITH FUROSEMIDE AND CELIAC SPRUE

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The clinical diagnosis of bullous pemphigoid (BP) can be challenging given the polymorphic nature of the disease. We present a case of erythema multiforme (EM)-like BP in an 80-year-old woman with celiac disease. Skin biopsies showed intraepidermal and subepidermal bullae with direct immunofluorsecence (DIF) demonstrated IgG and C3 linear deposition at the basement membrane. The etiology of our patient's BP is unclear but may be associated with furosemide usage and a flare of celiac sprue. To our knowledge, only four other published cases document EM-like lesions in BP. Atypical presentations of BP should be confirmed with histology and direct immunofluorescence.

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BULLOUS PEMPHIGOID IN TWO PATIENTS WITH PEMPHIGUS VULGARIS

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Bullous pemphigoid and pemphigus vulgaris are autoimmune conditions in which patients have autoantibodies to different skin epitopes, resulting in two distinct blistering dermatoses with distinct clinical and pathologic findings. Bullous pemphigoid presents with tense bullae due to antibodies directed against BP antigens 180 and 230, hemidesmosal proteins which function in dermal-epidermal adherence. Pemphigus vulgaris, on the other hand, presents with flaccid bullae due to antibodies directed against desmoglein 1 and 3, important components in the desmosomal attachments of cells to each other. Although these disorders are caused by autoantibodies directed against two different skin components, rare cases have been reported in which patients exhibit characteristics of both. Here we present two patients with pemphigus vulgaris who developed tense bullae that were histologically consistent with bullous pemphigoid.

TWO CASES OF UNILESIONAL MYCOSIS FUNGOIDES

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Mycosis fungoides (MF) is the most common form of cutaneous T-cell lymphoma. Unilesional MF is characterized by a single continuous area of involvement of less than 5% body surface area, with histopathological features indistinguishable from classical MF. We present two cases of this unique entity affecting the face. One patient achieved clearance with localized radiotherapy and has remained free of disease for three years. The second patient did not respond to topical therapy and is awaiting systemic chemotherapy. In the interim, this patient has developed a suspicious erythematous patch of his axilla, suggesting progression of his disease. Unilesional MF should be in the differential diagnosis for atypical dermatoses recalcitrant to standard therapy, and multiple biopsies from separate locations within the lesion may be required to establish the diagnosis. Additionally, in a minority of unilesional MF cases, recurrence distant from the original lesion may occur, suggesting progression to classical MF. Therefore, these patients should be monitored for recurrence or progression of their disease.

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DIFFERING MORPHOLOGIES AND PROGNOSES OF PRIMARY CUTANEOUS ANAPLASTIC LARGE CELL LYMPHOMA: REPORT OF TWO CASES

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Abstract: CD30+ lymphoproliferative disorders represent a spectrum of disease that includes lymphomatoid papulosis, primary cutaneous anaplastic large cell lymphoma (PCALCL), and node based anaplastic large cell lymphoma. PCALCL can present as either a solitary tumor or widespread multifocal disease. This is a presentation of two cases of PCALCL, one with localized disease and the other with widespread tumors. The first case involves a 74 year old woman with over 8 years of recurrent disease limited to her face, which has recurred several times despite treatment with radiation, PUVA, and systemic chemotherapy. The second case involves a newly diagnosed 51 year old male with more extensive skin involvement. The clinical features, histopathology, and treatment course for these patients will be presented, as well as a summary of the differing morphologies of this disease as it relates to prognosis.

A UNIQUE PRESENTATION OF MYCOSIS FUNGOIDES

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A 42-year-old African American woman presented with a four month history of increasing numbers of white patches involving the trunk, face, extremities. The lesions developed without preceding redness or scale and were asymptomatic. She denied systemic symptoms including fevers, weight loss, and night sweats. Physical examination revealed widespread hypopigmented macules and patches scattered over the face, anterior neck, chest and extremities. Differential diagnosis included vitiligo, hypopigmented sarcoidosis, hypopigmented mycosis fungoides, atypical pityriasis lichenoides chronica, and secondary syphilis. Punch biopsy showed changes consistent with mycosis fungoides (MF).

Hypopigmented MF is a rare variant of MF usually observed in dark-skinned individuals and children. The exact incidence is still unknown, but at least 105 cases have been documented in the literature. It generally exhibits a T suppressor CD8-positive phenotype and has a good prognosis. The mechanism of hypopigmentation in this form has not been fully elucidated. Hypotheses include transfer of melanosomes in the lesional skin to keratinocytes, degenerative changes in melanocytes due to inflammation, and direct cytotoxic injury of T lymphocytes. Hypopigmented MF is a diagnostic challenge. Patients may be misdiagnosed as having vitiligo, atopic dermatitis, postinflammatory hypopigmentation, and pityriasis alba. In addition, the hypopigmented lesions may be associated with erythematous plaques, tumors, or patches further obscuring the diagnosis. Treatments reported include psoralen UVA, UVB, topical chemotherapeutic agents, and topical corticosteroids. This case illustrates the need for increased clinical suspicion of MF in a patient presenting with widespread hypopigmentation.