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Conglomerated Facial Liposarcoma

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Dear Editor:

Liposarcoma is the most common soft-tissue tumor occurring in adults[1]. Most liposarcomas develop in the deep soft tissues of the extremities and retroperitoneum. Only a very small percentage occurs in the head and neck regions[2]. Although very large liposarcomas are not infrequently found in the intraabdominal regions or extremities, the head and neck liposarcomas mostly occur as small solitary mass which can usually be treated by surgical excision. We report a case of large conglomerated liposarcoma developed on the forehead.

A 74-year old woman presented with firmly palpable nodules on the forehead which had existed for 2 years (Fig. 1). Histopathologic evaluation revealed multivacuolated lipoblasts with nuclear pleomorphism and hyperchromatism scattered in the subcutaneous fat (Fig. 2A, B), which was consistent with the well-differentiated liposarcoma. Immunohistochemical stain with S-100 protein was positive in the adipocytes and some lipoblasts (Fig. 2C), while Ki-67 was negative. The magnetic resonance imaging (MRI) showed a large liposarcoma involving the entire forehead and soft tissues to the level of ethmoid

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sinuses. Neither positron emission tomography-computed tomography nor the neck computed tomography showed nodal involvement or distant metastasis. Initially, she was referred to the plastic surgery for surgical excision, but due to the large extent of the lesion, surgical removal was considered impossible. Instead, concurrent chemo-radiotherapy with doxorubicin (10 mg/m^2 weekly) was attempted as the primary treatment. Radiotherapy followed in the standard protocol with fractioned doses of 200 cGy, 5 days a week for 2 months. The facial MRI, 4 months after the initial visit, showed a decreased thickness of the tumor without metastatic lymph nodes.

Four histological variants, namely the well-differentiated, myxoid, round cell and pleomorphic liposarcomas, have been described[3]. The term well-differentiated liposarcoma, the most common subtype, has been designated to describe the nonmetastasizing, low-grade lipomatous tumors with a tendency for local recurrence. Histologically, it resembles the normal fat with scattered multivacuolated lipoblasts, featuring some nuclear pleomorphism and hyperchromatism. Although most authors agree that sarcoma label is appropriate when these lesions are found in retroperitoneum, when they are located in the extremities or elsewhere, some experts prefer the term atypical lipomatous tumor due to the favorable outcome after surgery and the nearly negligible effect on survival[4].

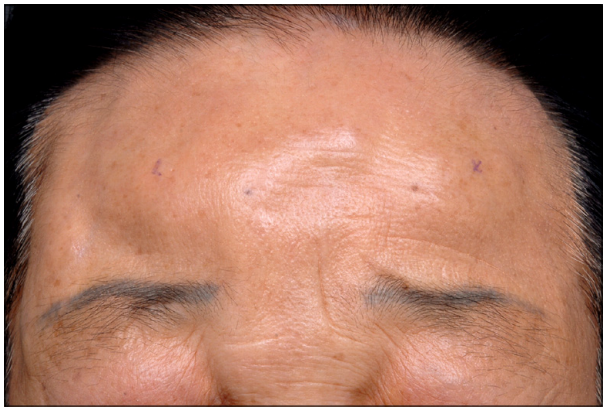

Fig. 1. Multiple firmly palpable subcutaneous nodules on the forehead.

Complete excision is the treatment of choice for all histologic subtypes. Patients with smaller, well-differentiated or myxoid liposarcomas without local extension may be observed after surgery. Neoadjuvant chemotherapy may be considered in patients with high-grade tumors and for those involving complex anatomical structures, and the use of the adjuvant postoperative chemotherapy would theoretically offer benefits to patients with aggressive tumors. Postoperative radiotherapy may be indicated for patients with high-grade tumors, positive margins, large tumors, local extension and complex anatomic subsites[5].

The present case is unique in its wide-spread, conglomerated nature and superficial location, which rendered surgical resection impossible. The reports regarding the treatment of facial liposarcomas without surgery are very limited in the literature. The well-differentiated liposarcomas show nearly 100% 5 year survival rate without metastasis, despite frequent local recurrence after surgery. In addition, scalp or face tumors are known to have a better prognosis than the oral tumors[1]. Long-term follow-up would be required to determine the treatment outcome.

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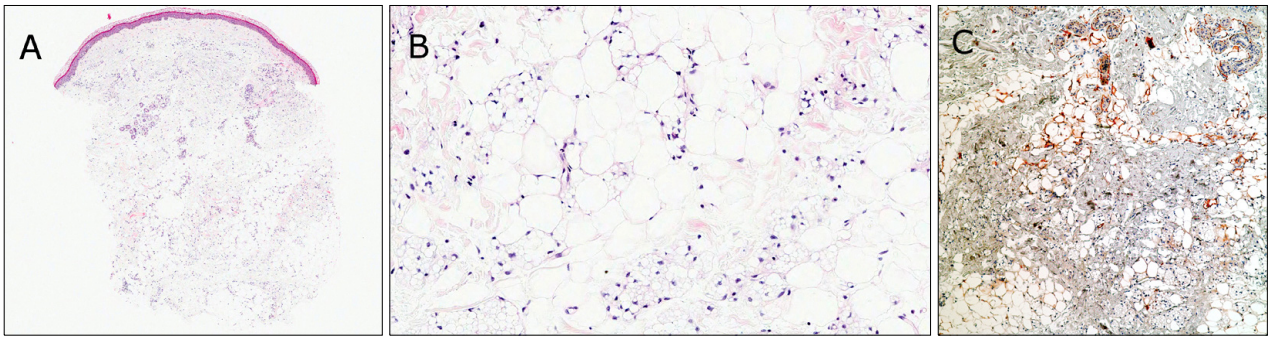

Fig. 2. (A, B) Histopathologic evaluation revealed multivacuolated lipoblasts with nuclear pleomorphism and hyperchromatism scattered in the subcutaneous fat (H&E; A: ×20, B: ×200). (C) S-100 protein was positive in the adipocytes and some lipoblasts (S-100; ×100).

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Eccrine Poroma Clinically Mimicking Ingrowing Toenail Complicated with Granulation Tissue

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Dear Editor:

Eccrine poroma is a benign tumor arising from the eccrine gland epithelium in the epidermis. It can occur anywhere in the body, where eccrine gland exists. Here, we report a case of eccrine poroma mimicking an ingrowing toenail complicated with granulation tissue, as this case can easily lead physicians to misdiagnosis.

A previously healthy 55-year-old man was presented with one month of solitary painful erythematous papule on margin of his first left-foot toenail. His past medical history was unremarkable.

On physical examination, we found a well-defined erythematous papule (0.5 cm in diameter) over the medial side of the left first toenail margin (Fig. 1). First impression was the granulation tissue caused by an adjacent ingrowing toenail. A shaving excision was performed.

Unexpectedly, histological examination confirmed eccrine poroma (Fig. 2). After three months, a new lesion recurred, and surgical excision had to be done for complete removal.

Eccrine poroma is a tumor arising from the eccrine duct epithelium in the epidermis, called acrosyringium. The majority of lesions occur on the palms and soles, as eccrine glands are concentrated in those areas. Eccrine poroma appears as an exophytic, skin colored or pink papule with a diameter of 1～2 cm. It is easily diagnosed based on typical clinical manifestations. As longstanding lesions can develop into malignant eccrine poromas, surgical removal is the primary treatment option.

Onychocryptosis, or ingrowing toenail, is a common nail disorder where the side of the nail plate penetrates the

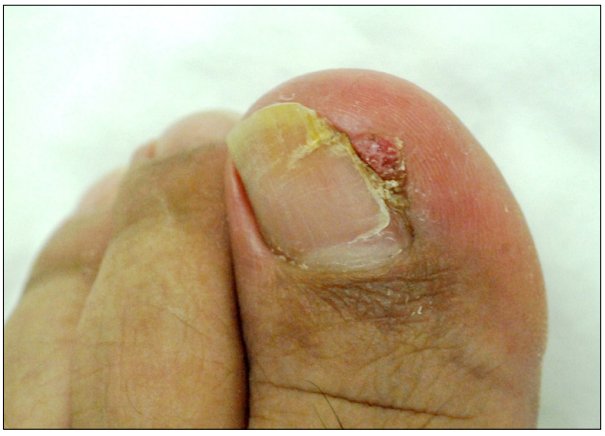

Fig. 1. Solitary well-defined erythematous papule (measured 0.5×0.5 cm in diameter) on the lateral fold of left first toenail.

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