Skin SCC associated with HPV outside the genital area usually occurs on distal digits, mainly involving the periungual and/or subungual skin [4]. The scalp is a rare site for HPV-associated SCC. How the mucous type of HPV is transmitted beyond the genital region is obscure. As for SCC of the fingers, autoinoculation from the genital tract to the fingers is generally suspected [4]. The type of HPV associated with SCC occurring outside the genital region is mainly the mucous high-risk type, as in the case of SCC of the fingers. This suggests the mucous type of HPV could be transmitted beyond the genital region via the fingers, and could be involved in the pathogenesis of SCC in any region. Since there have been male patients with HPV-related skin tumors [5], HPV could also be transmitted from the sexual partner. Although we did not check this patient for anogenital lesions, HPV type 16 may have been transmitted via the fingers from the external genitalia to the scalp. The HPV E7 oncogene product binds to and inactivates Rb tumor suppressor gene products. Inactivation of Rb upregulates the expression of p16INK4a proteins through a negative feedback mechanism [2]. Therefore, although it is considered to be a bystander effect, overexpression of p16INK4a protein is suggested to be a marker of high-risk type HPV infection in cervical cancer [2, 6]. Previous studies showed p16INK4a expression is also higher in HPV-positive lesions compared with HPV-negative lesions of skin SCC [5]. In our case, the tumor cells did not show any staining for Rb, but showed strong and diffuse staining for p16INK4a. Dysregulation of the Rb/p16INK4a pathway by mucous high-risk HPV type 16 may have been involved in the pathogenesis of the lesion in our case, although the precise pathogenesis remains to be elucidated.

**Giant cell collagenoma on the palm**

Giant cell collagenoma (GCC) is a rare, benign, cutaneous, fibrous tumor that usually affects the face, trunk and upper limbs of young adults [1]. Since its first description, there have been only two additional case reports considered as GCC in the English literature [2, 3]. We report another case of GCC that affected the palm of a 68-year-old, female patient.

A 68-year-old female presented with a solitary, skin-colored nodule on her left palm that had gradually increased in size since its appearance six months previously. The patient denied any history of antecedent trauma or systemic illness, except hypertension. A physical examination revealed a 0.7 × 0.8-cm-sized, firm, intradermal nodule without surface change, on the left palm (figure 1A). Histological examination of the excised lesion showed a well-circumscribed, non-capsulated, dome-shaped nodule in the dermis with significant atrophic change of the overlying epidermis and a thin epidermal “collarette” (figure 1B). The lesion consisted of coarse, hyalinized collagen bundles arranged in a storiform pattern (figure 1C). Throughout the lesion, there were numerous large multinucleated giant cells...
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Disseminated bilateral hyperkeratotic variant of porokeratosis Mibelli with pruritus

Porokeratosis represents a heterogenous group of skin disorders characterized by variably sized papules or plaques with a fine peripheral keratotic rim and central atrophy and the histologic finding of cornoid lamella [1]. Since Mibelli's