Plaque on the Thigh of a Renal Transplant Recipient
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REPORT OF A CASE
A 45-year-old man was referred to our dermatology outpatient clinic from the renal transplantation clinic. His medical history included thalassemia minor, familial polyposis coli, hypertension, and IgA nephropathy that resulted in kidney transplantation. For the last 4 years, he had been treated with the following immunosuppressive therapy: azathioprine (100-150 mg/d), cyclosporine (540-130 mg/d), and prednisone (10-40 mg/d).

Physical examination and routine laboratory tests revealed no abnormalities other than slightly enlarged inguinal lymph nodes bilaterally and a soft, skin-colored plaque on the upper part of the right thigh, with overlying nodules that looked similar to vesicles. The lesion was 10 cm in greatest diameter (Figure 1). Computed tomography revealed thickening of the skin and infiltration of the subcutis in the medial aspect of the proximal part of the right thigh. A skin biopsy was performed (Figure 2 and Figure 3).

What is your diagnosis?

Asymptomatic Nodule on the Upper Lip
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REPORT OF A CASE
A 22-year-old man presented with an 18-month history of a slow-growing, asymptomatic nodular lesion on his upper lip. Physical examination revealed a dark-red, firm, dome-shaped nodule, measuring 8 mm in diameter, with an adherent scale covering the central part of its surface (Figure 1 and Figure 2). The patient appeared to be in good general health, and routine laboratory investigations showed no abnormalities. The lesion was completely excised for light microscopic examination (Figure 3).

What is your diagnosis?

Brownish Reticulate Maculopapular Eruption on the Flexures
Eyal Peretz, MD; Marcelo H. Grunwald, MD; Dafna Hallel-Halevy, MD; Sima Halevy, MD; Soroka University Medical Center, Ben-Gurion University of the Negev, Beer-Sheva, Israel

REPORT OF A CASE
A 76-year-old woman presented with an 18-month history of a pruritic eruption on the flexures. She denied episodes of headache, nausea, vomiting, diarrhea, abdominal pain, or palpitations. Her medical history was remarkable for diabetes mellitus and hypertension. Her medications included atenolol and glibenclamide.

On physical examination, multiple confluent brownish macules and papules that formed a reticulate pattern were present symmetrically on the axillae (Figure 1), in the submammary region, and at the inguinal folds. A wheal and flare reaction was noted after the site was rubbed. The results of routine blood tests and urinalysis were within normal limits. Abdominal ultrasonography revealed a fatty liver, and the findings of isotopic scanning of bones with technetium 99m were normal. A biopsy was performed (Figure 2 and Figure 3).

What is your diagnosis?

An Asymptomatic Preauricular Subcutaneous Nodule in a 65-Year-Old Woman
Sang-Jae Lim, MD; Riu-Chong Chiu, MD; National Taiwan University Hospital and National Taiwan University College of Medicine, Taipei

REPORT OF A CASE
A 65-year-old Taiwanese woman presented with a 10-year history of a slow-growing asymptomatic mass in her left preauricular area. Her medical history was unremarkable, and no pertinent family history was reported. Physical examination revealed a movable, elastic, nontender subcutaneous nodule, measuring approximately 2 cm in diameter, in the left preauricular area (Figure 1). The nodule was excised for histologic examination (Figure 2 and Figure 3).

What is your diagnosis?
Asymptomatic Nodule on the Upper Lip

**Diagnosis**
Cutaneous mastocytosis (urticaria pigmentosa, UP).

**Microscopic findings**
Histopathological examination revealed a dense dermal in- filtrate, predominantly composed of large histiocytes and mononuclear cells resembling active mast cells. The collagen fibers were stretched and hyperplastic, with abundant granular cytoplasm and a central nucleus. The granulatory granules of the mast cells stained metachromatically with Giemsa stain.

**Clinical course**
The patient was treated with oral antihistamines and a systemic corticosteroid tapering therapy over the course of several months. At the last follow-up visit 6 months after initial diagnosis, the lesion was completely resolved.

**Discussion**
Mastocytosis is best considered a spectrum of rare clini- cal entities: solitary cutaneous mastocytoma,1 cutaneous mastocytosis with systemic involvement,2 and mastocytosis with systemic disease.3 The skin lesions in all these condi- tions demonstrate an identical histologic pattern that is characterized by the presence of numerous mononuclear or multinucleated histiocytes with abundant, azuro- philic, homogeneous to finely granular cytoplasm with a round to oval shape and abundant granular cytoplasm and a central nucleus.4 Abundance of the 3 components varies and may be accentuated. A dense dermal infiltrate, predominantly composed of large histiocytes resembling active mast cells, is characteristic of mastocytosis.3,5 The prominent infiltration of histiocytes in the upper dermis may be associated with the appearance of Blaschkolinear patterns, which are characteristic of mastocytosis.6

Brownish Reticulate Maculopapular Eruption on the Flexures

**Diagnosis**
Cutaneous angiomatous fibrohistiocytoma.

**Microscopic findings**
Histopathologic examination revealed a dense dermal in- filtrate, predominantly composed of histiocytes and fibroblasts. The collagen fibers were stretched and hyperplastic, with abundant granular cytoplasm and a central nucleus. The granulatory granules of the mast cells stained metachromatically with Giemsa stain.

**Clinical course**
The patient was treated with oral antihistamines and a systemic corticosteroid tapering therapy over the course of several months. At the last follow-up visit 6 months after initial diagnosis, the lesion was completely resolved.

**Discussion**
Mastocytosis is best considered a spectrum of rare clini- cal entities: solitary cutaneous mastocytoma,1 cutaneous mastocytosis with systemic involvement,2 and mastocytosis with systemic disease.3 The skin lesions in all these condi- tions demonstrate an identical histologic pattern that is characterized by the presence of numerous mononuclear or multinucleated histiocytes with abundant, azuro- philic, homogeneous to finely granular cytoplasm with a round to oval shape and abundant granular cytoplasm and a central nucleus.4 Abundance of the 3 components varies and may be accentuated. A dense dermal infiltrate, predominantly composed of large histiocytes resembling active mast cells, is characteristic of mastocytosis.3,5 The prominent infiltration of histiocytes in the upper dermis may be associated with the appearance of Blaschkolinear patterns, which are characteristic of mastocytosis.6

References

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