

we were not able to find the primary tumour. Remarkably, no primary tumour is found in about 5% of the patients with breast cancer metastasis (4). Some of these women may suffer from a carcinoma of dystopic breast glands, seen in 1–5% of the female population (5).

In conclusion, our case report demonstrates that MR is not only a marker for manifest or occult malignancy, but also for metastasis from an unknown primary tumour. The disease fulfils all the criteria of a paraneoplastic syndrome, indicating that all patients with MR should be evaluated and monitored carefully.

REFERENCES

1. Snow JL, Su WPD. Histiocytic diseases. *J Am Acad Dermatol* 1995; 33: 111–125.
2. Goerdts S, Fartasch M, Kodolija V, Sorg C. Histiocytozen:

Klassifikation und zelluläre Pathobiologie. In: *Jahrbuch der Dermatologie – Tumoren der Haut*. Zülrich: Biermann; 1995. p. 40–65.

3. Snow JL, Muller SA. Malignancy-associated multicentric reticulohistiocytosis: a clinical, histological and immunophenotypic study. *Br J Dermatol* 1995; 133: 71–76.
4. Abruzzese JL, Abruzzese MC, Lenzi R. Analysis of a diagnostic strategy for patients with suspected tumours of unknown origin. *J Clin Oncol* 1995; 13: 2094–2103.
5. Daugaard G. Unknown primary tumours. *Cancer Treat Rev* 1994; 20: 119–147.

Received June 18, 1997.

M. Worm¹, A. Kleine-Tebbe², E. v. Stebut¹, N. Haas¹ and G. Kolde¹
Departments of ¹Dermatology and ²Gynecology, Charité and Virchow-Klinikum, Humboldt-Universität, ¹Schumannstr. 20–21, DE-10117 Berlin, Germany.

Agminated Xanthogranuloma: An Unusual Presentation of Juvenile Xanthogranuloma

Sir,

Juvenile xanthogranuloma is a benign histiocytic lesion, which most commonly occurs in children as small yellowish papules generally less than 1 cm in size (1). A macronodular variant has been reported in infants, with lesions measuring as large as 10 cm (2–4). We here report on 2 adults with asymptomatic agminated papules, which coalesced to form multinodular plaques on the extremities.

CASE REPORTS

Case 1

An 18-year-old Russian immigrant complained of an asymptomatic skin lesion of the forearm, which had been present for approximately 1 month. His general health was excellent and he took no medications. He was a student and had been in the United States for one and a half years. There was no history of trauma to the site.

On physical examination there was a plaque on the left forearm, composed of numerous coalescing papules (Fig. 1). The area was indurated, devoid of hair, and measured approximately 4.0 × 3.0 cm. The most superficial papule was yellow brown in color, whereas the deeper seated component was flesh-colored. A few satellite lesions were palpable along the ulnar aspect of the forearm. There was no regional adenopathy, and no café au lait spots or other stigmata of neurofibromatosis were present.

Laboratory results, including complete blood count, chemistry panel, cholesterol and triglycerides, were unremarkable. Radiographs of the left forearm and chest were normal. A skin biopsy demonstrated a proliferation of foamy histiocytes, which were admixed with numerous eosinophils. Tissue cultures (including aerobic, fungal and mycobacterial cultures) were negative. Electron microscopy showed a sheet-like infiltrate of mononuclear cells with abundant cytoplasm and numerous organelles. The cells demonstrated in-folded reniform nuclei and numerous primary lysosomes and phagolysosomes characteristic of histiocytes. Additionally, cytoplasmic lipid vacuoles typical of early foam cell formation were noted. Birbeck granules were not identified, and the lesion was classified as a non-Langerhans' cell histiocytosis.

Case 2

A 42-year-old woman complained of a lesion of the left inner thigh, which had been present for approximately 1 year. It reportedly began



Fig. 1. A plaque on the left forearm is composed of numerous coalescing papules. Note satellite lesions and alopecia.

as a "red sore" and subsequently became firm and nodular. The patient was in good health and her only medication was aspirin. She had a history of shaving the bikini line in that area.

On examination, there was a 6.0 × 4.0 cm indurated plaque, with reddish-brown papules within it (Fig. 2). Laboratory results were unremarkable (complete blood count, chemistry panel and triglycerides). Her cholesterol was slightly elevated at 204. A skin biopsy showed a nodular dermal infiltrate of bland appearing histiocytes, some of which were multinucleated. Touton-type giant cells were not observed. Tissue cultures (aerobic, fungal, mycobacterial) showed no growth. A skin biopsy was interpreted as a xanthogranuloma.

DISCUSSION

Juvenile xanthogranuloma has been described in adolescents and young adults (5). In this setting, the entity may present as isolated or multiple lesions. Multiple lesions are frequently irregularly scattered in distribution. Both of our patients presented with a localized clustering of papules. This agminated appearance, a finding which initially led to some diagnostic confusion, has not been well described in the literature. Recently, the occurrence of coalescing papules was described on the nape of the neck of an infant (6). The authors suggested the term "clustered juvenile xanthogranuloma" for this entity. We report 2 additional cases occurring in adults. The presence of alopecia mucinosa, surrounding induration and satellite papules extending in a linear array from the tumor were additional worrisome clinical features in one of the patients. Histologically, juvenile xanthogranulomas are characterized by nodular dermal infiltrates, composed primarily of histiocytes, with foam cells and multinucleated and Touton-type giant cells. The infiltrate may be admixed with lymphocytes, neutrophils and eosinophils. A previous study of juvenile xanthogranulomas noted that foam cells and giant cells may not always be present in these lesions and are not requisite for diagnosis (7). Follicular mucinosis was observed in one of our patients, and this has not previously been reported in xanthogranulomas. Electron microscopy supported the diagnosis of xanthogranuloma and was helpful in excluding histiocytosis X.

These 2 cases provide additional clinical and histological features which may occur as part of the spectrum of juvenile xanthogranulomas and should not be mistaken as signs of malignancy.

REFERENCES

1. Helwig EB, Hackney VC. Juvenile xanthogranuloma (nevooxantho-endothelioma) [Abstract]. *Am J Pathol* 1954; 30: 625-626.
2. Campbell L, McTigue MK, Esterly NB, Rosenbaum M. Giant juvenile xanthogranuloma [Letter]. *Arch Dermatol* 1988; 124: 1723-1724.
3. Schwartz TL, Carter KD, Judisch GF, Nerad JA, Folberg R. Congenital macronodular juvenile xanthogranuloma of the eyelid. *Ophthalmology* 1991; 98: 1230-1233.
4. Seo IN, Min KW, Mirkin D. Juvenile xanthogranuloma: ultrastructural and immunocytochemical studies. *Arch Pathol Lab Med* 1986; 110: 911-915.
5. Rodriguez J, Ackerman AB. Xanthogranuloma in adults. *Arch Dermatol* 1976; 112: 43-44.
6. Caputo R, Grimalt R, Gelmetti C, Cottoni F. Unusual aspects of juvenile xanthogranuloma. *J Am Acad Dermatol* 1993; 29: 868-870.
7. Shapiro PE, Silvers DN, Treiber RK, Cooper PH, True LD, Lattes R. Juvenile xanthogranuloma with inconspicuous or absent foam cells and giant cells. *J Am Acad Dermatol* 1991; 24: 1005-1009.

Fig. 2. A multinodular plaque is present on the left inner thigh.



Accepted June 25, 1997.

Ibrahim A. Tangoren¹, Jeffrey M. Weinberg^{2*}, Tatanya Humphreys¹, George F. Murphy¹, David J. Margolis¹ and Elizabeth M. Spiers¹
Departments of Dermatology, ¹University of Pennsylvania School of Medicine, Philadelphia, PA, and ²New York Medical College-Metropolitan Hospital Center, New York, NY, USA

*Metropolitan Hospital Center, Department of Dermatology, 1901 First Avenue, New York, NY 10029, USA.

Fixed Drug Eruption Due to Melatonin

Sir,

Melatonin is a hormone synthesised by the pineal gland. Its secretion is principally controlled by the prevailing light-dark environment, and for this reason it is called the "hormone of darkness" (1). It has recently been synthesised in the laboratory, and the oral form is now available for investigational use.

The physiological role of melatonin in humans is still unknown. It has been hypothesized that this hormone has an anticancer activity and is a good treatment for some mental diseases, sarcoidosis, rheumatoid arthritis, AIDS, insomnia and headache. It also seems to delay or prevent ageing ("pill

of youth"). The most satisfying results with exogenous melatonin have been obtained for jet lag syndrome (2, 3), delayed sleep-phase syndrome (4) and some kinds of chronic insomnia.

Here we present two cases of fixed drug eruption of the genitalia due to melatonin.

CASE REPORTS

A 35-year-old man was referred to our department to evaluate the presence of itching, burning and sharply margined, erythematous