Sir,
Cutaneous metastases (CM) represent a specific skin manifestation of an internal malignancy (1). The overall incidence of metastatic disease in the skin is low, and most authors consider the clinical incidence of CM to be 0.7-9% (1). CM of thyroid carcinoma are very rare. Only 31 cases have been reported in the medical literature (2-5). We report a case of CM from a follicular carcinoma of the thyroid gland.

A 57-year-old woman had 12 years previously had a total mastectomy for a breast adenocarcinoma. In 1986 a follicular carcinoma of the thyroid gland was diagnosed. She underwent a total thyroidectomy and was subsequently treated with radioactive iodine (131I) and hormonal therapy. In 1991, a local recurrence was noted. She was treated with total laryngectomy and lymph node dissection and a higher dose of 131I was administered. Seven months later, she developed two solid tumors on the right retroauricular area and on the left side of the parietal scalp (Fig. 1). The tumoral lesions were resected. Routine histopathologic study of the skin biopsy specimen revealed an atypical proliferation of epithelial cells, affecting dermis with solid aggregation. Large and dilated vessels could be seen within and around the tumor. Pale-basophilic cytoplasm and hyperchromatic nuclei were observed in the tumoral cells. They were occasionally arranged in microfollicle-like structures with different amounts of eosinophilic deposits (Colloid). Periodic-acid-Schiff stain showed intense staining of the colloid as well as the cytoplasm of the cells. Immunohistochemical study with polyclonal antibody against thyroglobulin, using the peroxidase-antiperoxidase technique, demonstrated positive stain in the cytoplasm of the tumor cells and in the lumina of some follicles (Fig. 2). Scintigraphy with radioactive iodine did not detect any extrathyroidal sites of suspicious metastases. The patient is still alive and is being treated with 131I and substitutional therapy.

In previously reported cases, most lesions present as solitary or multiple painless skin tumors of less than 25 mm. The color is usually violet due to the rich blood supply, and vascular neoplasms are the main differential diagnosis for this reason. CM from thyroid carcinoma are frequently located on the head and neck. CM from carcinoma of the kidney are also often located in the scalp and sometimes the tumor presents with the skin involvement (6). The histopathologic diagnosis of the skin specimens may be difficult. Cutaneous metastatic lesions show occasionally an undifferentiated pattern (6). In some cases, like ours, two different primary tumors may be present in the same patient. Immunohistochemical techniques may be useful in these special cases, in which routine stains do not make clear the primary tumor. Endocrine secretion, if present, will be clear by this technique. In our case, CM from breast adenocarcinoma was ruled out by the use of immunohistochemistry with antithyroglobulin monoclonal antibodies.

REFERENCES
Confluent and Reticulated Papillomatosis (Gougerot-Carteaud) of the Pubic Region

Sir,

Confluent and reticulated papillomatosis (CRP) is characterized by a popular eruption distributed most often in the intermammary and interscapular regions and on the neck and abdomen. A case of CRP in which the lesions appeared in the pubis was reported by Broberg & Faergemann (1). We found a similar lesion in the pubic region of a 15-year-old white girl, with brownish papules measuring 3–4 mm in diameter, arranged in a reticular pattern, coalescing into a verrucous plaque of 5–6 cm in diameter (Fig. 1). On examination the lesions showed a yellow fluorescence with Wood’s lamp.

Histological examination of the lesion showed marked hyperkeratosis, slight acanthosis and papillomatosis. PAS stain revealed spores and a few hyphae characteristic of *Pityrosporum ovale* in the stratum corneum. Direct microscopic examination and a fungal culture obtained from the lesions were negative. The patient was treated with 5% salicylic acid ointment, with only slight improvement. Better results were seen with further topical treatment with 2.5% selenium sulphide.

Our case and the one presented by Broberg & Faergemann may represent a variation of CRP which is characterized by an unusual location – the pubis. It may be suggested that this variant of CRP is more common than reported in the literature.

REFERENCES


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