histologically showed vascular proliferation with abundant histiocytic infiltration. Progressive ulceration made AITL diagnose more difficult until the lymph node biopsy result was obtained. However, PD-1 staining for the lymph node and the skin was useful in making the diagnosis[2]. Until now, predominant histiocytic infiltrate in cutaneous AITL such as our case has not been described. Only a few AITL cases have been reported with nodular lesion histologically showing presence of histiocytes. Although histiocytes' role in cutaneous lymphoma has been described in prominent granulomatous reaction, most cases were of mycosis fungoides[3] and rare cases of AITL. CD68 has been known as negative prognostic marker for lymphoma-associated macrophage in follicular lymphoma[4] and classic Hodgkin's lymphoma[5]. In our opinion, abundant histiocytic infiltration in cutaneous AITL may be associated with the cutaneous nodules and also with the progressive ulcer, and histiocytes might play a more aggressive role in the clinical features of AITL, which will be evaluated in the future.

REFERENCES

1. Balaraman B, Conley JA, Sheinbein DM. Evaluation of cutaneous angioimmunoblastic T-cell lymphoma. J Am Acad Dermatol 2011;65:855-862.
2. Roncador G, Verdes-Montenegro JFG, Tedoldi S, Paterson JC, Klapper W, Ballabio E, et al. Expression of two markers of germinal center T cells (SAP and PD-1) in angioimmunoblastic T-cell lymphoma. Haematologica 2007;92:1059-1066.
3. Scarabello A, Leinweber B, Ardigó M, Rütten A, Feller AC, Kerl H, et al. Cutaneous lymphomas with prominent granulomatous reaction: a potential pitfall in the histopathologic diagnosis of cutaneous T- and B-cell lymphomas. Am J Surg Pathol 2002;26:1259-1268.
4. Farinha P, Masoudi H, Skinnider BF, Shumansky K, Spinelli JJ, Gill K, et al. Analysis of multiple biomarkers shows that lymphoma-associated macrophage (LAM) content is an independent predictor of survival in follicular lymphoma (FL). Blood 2005;106:2169-2174.
5. Steidl C, Lee T, Shah SP, Farinha P, Han G, Nayar T, et al. Tumor-associated macrophages and survival in classic Hodgkin's lymphoma. N Eng J Med 2010;362:875-885.

http://dx.doi.org/10.5021/ad.2016.28.3.393

Cutaneous Metastatic Rectal Adenocarcinoma in Zosteriform Distribution

In Hyuk Kwon, Heesang Kye, Soo Hong Seo, Hyo Hyun Ahn, Young Chul Kye, Jae Eun Choi

Department of Dermatology, Korea University College of Medicine, Seoul, Korea

Dear Editor:

A 54-year-old woman presented with mildly stinging, painful, grouped nodules on the left vulvar area. It shows unilateral localized grouped papulonodular lesions, resembling a zosteriform aspect (Fig. 1). The patient had a history of stage IV rectal adenocarcinoma with liver and

Received March 16, 2015, Revised May 4, 2015, Accepted for publication June 1, 2015

Corresponding author: Jae Eun Choi, Department of Dermatology, Anam Hospital, Korea University College of Medicine, 73 Inchon-ro, Seongbuk- gu, Seoul 02841, Korea. Tel: 82-2-920-5470, Fax: 82-2-928-7540, E-mail: zen129@naver.com

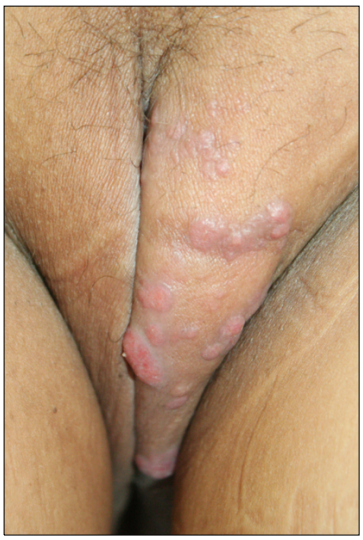

Fig. 1. Stinging painful erythematous grouped nodules on the left vulvar area.

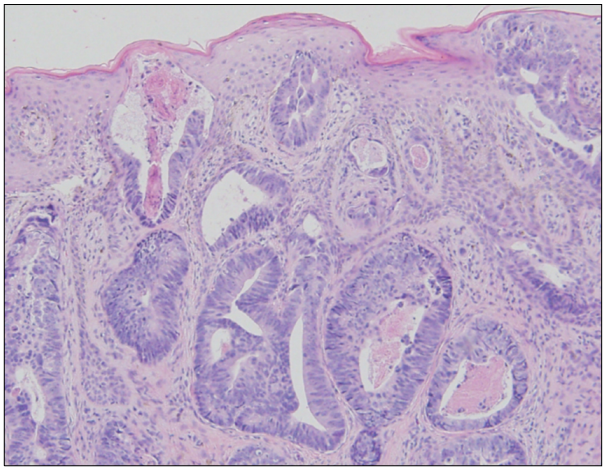

Fig. 2. Dermal infiltration by intestinal type atypical glands, showing metastatic skin adenocarcinoma (H&E, ×100).

lung metastases treated 17 months earlier with ultra-low anterior resection and chemotherapy. The patient also received external pelvic irradiation of 180 cGy/day, up to total 6,300 cGy/35 fractions, for recurrent adenocarcinoma at the anastomosis site. She presented with a zosteriform eruption on the left vulvar area during hospitalization, with no prior history of herpes zoster. The skin lesions exhibited predominantly nodular infiltration, inadequate for the tzanck test. A skin punch biopsy was performed under the differential diagnosis of herpes zoster on the left S2 dermatome, postherpetic granuloma, and cutaneous metastasis. Histopathology revealed metastatic adenocarcinoma (Fig. 2). The chest computed tomography (CT), abdomen CT, and positron emission tomographic-CT images showed consistent results of an increasing size of lung and hepatic nodules with lymph node metastasis. Pain around the vulva area was aggravated after repetitive chemotherapy and radiotherapy. Wide excision was performed to resect the visible cutaneous nodules with patient consent. The patient died eight months after the diagnosis of cutaneous metastasis, which was three years after the initial diagnosis of rectal adenocarcinoma. While the mean survival time from the diagnosis of cutaneous metastasis of colorectal cancer is 18 months[1], our patient died in a shorter time span. Cutaneous metastasis from an internal malignancy is rare and can appear in many different forms, including the multiple nodular type, inflammatory or erysipeloid form, sclerodermoid form, alopecia neoplastica, or bullous form. The nodular type is the most common clinical appearance, while the zosteriform pattern is very rare[2]. The exact mechanism of zosteriform cutaneous metastasis is unknown. A Koebner-like phenomenon at the site of herpes zoster, invasion of the perineural lymphatic or dorsal root ganglion, direct invasion of tumor cells, and accidental surgical implantation have all been proposed[2,3]. Colonofiberscopy and magnetic resonance imaging revealed an ulcerated fungating mass located on the left posterolateral wall of rectum. The metastatic lesion of the vulva was observed about 17 months later after a laparoscopic resection. However, an asymptomatic skin lesion may have appeared earlier. It is possible that the metastatic skin lesions may have been due to direct seeding of the tumor cells to the left side, but the exact mechanism remains unclear. The patient was undergoing chemotherapy when the metastatic lesions were observed, and herpes zoster occurs more frequently in immunosuppressed patients. It has been reported that many patients with cutaneous metastasis of zosteriform distribution are initially misdiagnosed with herpes zoster and treated with antiviral drugs[4]. Considering the pain and unilaterality, this may be easily misdiagnosed as herpes zoster. Herein, we report an unusual case of cutaneous metastasis of rectal adenocarcinoma that mimicked herpes zoster. This must be considered in any patient with a history of malignant neoplasm experiencing non-healing zosteriform lesions. Therefore, early biopsy for suspicious skin lesions is very important.

REFERENCES

1. Eichinger J, George B, Myhand R. Cutaneous metastatic rectal carcinoma masquerading as herpes zoster. South Med J 2011;104:233-235.
2. Rao R, Balachandran C, Rao L. Zosteriform cutaneous

metastases: a case report and brief review of literature. Indian J Dermatol Venereol Leprol 2010;76:447.
3. Savoia P, Fava P, Deboli T, Quaglino P, Bernengo MG. Zosteriform cutaneous metastases: a literature meta-analysis and a clinical report of three melanoma cases. Dermatol Surg 2009;35:1355-1363.
4. Zalaudek I, Leinweber B, Richtig E, Smolle J, Hofmann-Wellenhof R. Cutaneous zosteriform melanoma metastases arising after herpes zoster infection: a case report and review of the literature. Melanoma Res 2003;13:635-639.

http://dx.doi.org/10.5021/ad.2016.28.3.395

Interstitial Granulomatous Dermatitis Associated with Rheumatoid Arthritis

Yoon Seob Kim, Ji Hyun Lee, Jun Young Lee, Young Min Park

Department of Dermatology, Seoul St. Mary's Hospital, College of Medicine, The Catholic University of Korea, Seoul, Korea

Dear Editor:

Interstitial granulomatous dermatitis (IGD) is a rare and peculiar disorder with cutaneous and joint manifestations[1]. IGD may be associated with rheumatologic and hematologic disorders of underlying malignancies[2,3]. Herein, we report a case of IGD associated with rheumatoid arthritis (RA).

A 59-year-old Korean woman presented with multiple erythematous plaques on both extremities for 10 days (Fig. 1A). Upon physical examination, the plaques were linear shaped, non-tender, and palpable. She had been diagnosed with RA 17 years earlier. She had taken prednisolone, nonsteroidal anti-inflammatory drugs, and methotrexate to treat RA for 7 years. One month earlier, her arthritis symptoms had stabilized and the rheumatologist withdrew methotrexate. Laboratory test findings were non-specific except for an elevated C-reactive protein (CRP) level (7.12 mg/dl; normal range, 0.01～0.47 mg/dl) and erythrocyte sedimentation rate (ESR) (81 mm/h; normal range, 0～15 mm/h). Histopathologic findings indicated perivascular and interstitial lymphohistiocytic infiltration through the dermis and chronic granulomatous inflammation with collagen degeneration in the upper dermis. Immunohistochemically, most of the infiltrating inflammatory cells were CD 68-positive. Alcian blue staining revealed no mucin deposition in the areas of granulomatous inflammation (Fig. 2). Based on clinical and histological findings, she was diagnosed with IGD. A 7.5-mg methotrexate dose was given weekly and the daily prednisolone dose was increased from 5 mg to 15 mg. A topical 0.1% tacrolimus ointment and methylprednisolone cream were also applied daily for 2 months. The lesions were nearly cleared and ESR and CRP were found to be within normal limits after 2-month follow-up (Fig. 1B).

The most common clinical findings of IGD are asymptomatic multiple papules and plaques (70%～90% of cases)[2]. The "rope sign" was named for the linear prominent cutaneous cord-like lesions, considered pathognomic for IGD[1]. However, these lesions are not an essential feature, and are reported in only 9% of cases[3]. The histopathologic findings show interstitial CD 68-positive histiocyte infiltration around focally degenerated collagen[2,4]. Epidermal

Received January 2, 2015, Revised May 16, 2015, Accepted for publication June 8, 2015

Corresponding author: Young Min Park, Department of Dermatology, Seoul St. Mary's Hospital, College of Medicine, The Catholic University of Korea, 222 Banpo-daero, Seocho-gu, Seoul 06591, Korea. Tel: 82-2-2258-6223, Fax: 82-2-594-3255, E-mail: yymmpark6301@hotmail.com