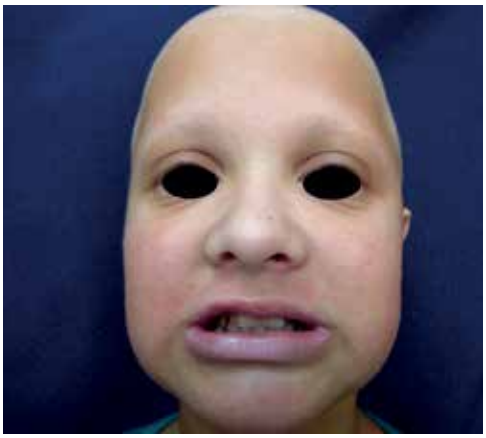

Figure 2: Clinical aspect of total alopecia and dentition

Figure 3: Eyebrow dermoscopy: sparse vellus hair on the face

contribution for establishing this type of disease's hereditary nature due to the significant association with VDDRII. Histological exam performed on the alopecia area demonstrates thinning and hypoplastic hair follicles, with no specific scarring or inflammatory characteristics.[1] Frequent biochemical alterations contribute to the diagnosis: high calcitriol with normal calcidiol, hypocalcemia, increased alkaline phosphatase, and phosphaturia and hypophosphatemia.[1,2,3] Treatment, which is based on a supplementation consisting of a high dose (30 to 60 ug/day) of vitamin D and calcium taken orally (up to 3g/day), is essential before reaching three years of age in order to avoid potentially fatal complications.[1] In the case reported here, as well as in cases described in the literature, specific VDDRII treatment, with calcium and vitamin D supplementation, as well as several options for alopecia treatment, have not contributed to the clinical improvement of alopecia. ❑

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Exuberant angiosarcoma*

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Dear Editor,

We report the case of a white, female patient, 78 years of age, presenting an erythematous rash on the face for the past two months, which was asymptomatic but was gradually increasing in size. She had used antibiotics and acyclovir, with no improvement in the lesion. Dermatological examination revealed an erythematous-violaceous plate, with revealed an, and accentuated follicular ostia, affecting the scalp, the upper eyelid, and preauricular, frontal, and mandibular areas, on the left side (Figure 1a). An incisional biopsy performed revealed preserved epidermis and dermis with diffuse infiltration of vascular clefts slits, which dissect collagen fibers, corresponding to pleomorphic ectasic vascular channels with atypical endothelial cells (Figure 2). The immunohistochemical pattern revealed positive CD31, CD34, Vimentin, and Ki67, confirming angiosarcoma (Figure 3).

We chose to start chemotherapy with a weekly 80mg/m^2 dose of paclitaxel. After six weeks, a nearly full remission of the skin lesion was observed, leaving only residual hypochromia areas (Fig-

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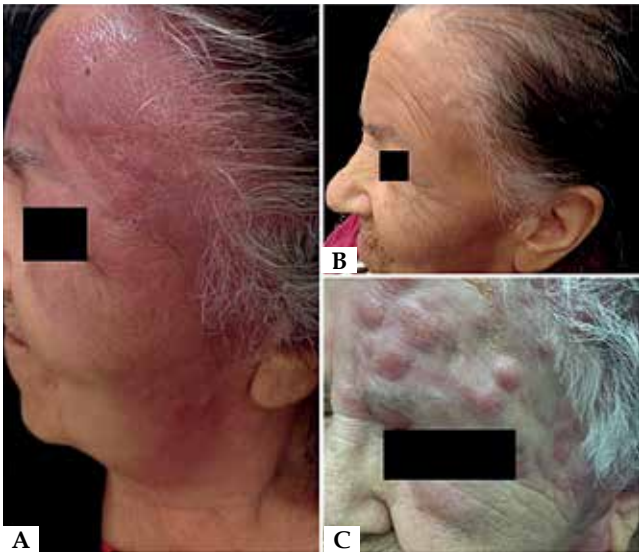

Figure 1: A- Erythematous-violaceous plaque. **B-** Full remission of the lesion after six week of chemotherapy. **C-** Erythematous nodules: recrudescence one month after chemotherapy end

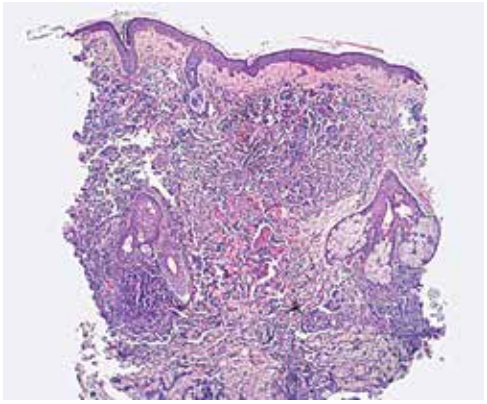

Figure 2: Histopathology: ectasic vascular channels dissecting collagen fibers, 40 HE

ure 1b). Nevertheless, the patient completed twelve weeks of treatment. One month after chemotherapy had ended, however, the tumor recrudesced, and erythematous nodules appeared on the same topography as before, with an exulceration area and a purulent discharge (Figure 1c). Treatment with paclitaxel was restarted, with no response after three weeks. Therefore, we chose to switch medication and started the patient on liposomal doxorubicin, 55mg/m^2, every four weeks, but without clinical improvement. Palliative care was started for the patient, evolved to death 14 months after diagnosis.

Four skin angiosarcoma variants are recognized nowadays: scalp and face angiosarcoma, lymphedema angiosarcoma (Stewart-Treves syndrome), radiation induced angiosarcoma, and epithelioid angiosarcoma.[1] Scalp and face angiosarcoma, the variant exhibited by the patient in the study, is the most common subtype, usually presents an insidious onset, is usually displayed as a violaceous rash, or as nodules, plaques or infiltrate areas. In the most advanced phases, it may bleed or ulcerate. Clinical differential diagnoses include seborrheic dermatitis, ecchymosis, hemangioma, cellulitis, erysipela, rosacea, angioedema, melanoma and Kaposi's sarcoma.[2] In histopathology, pleomorphic malignant endothelial cells may be noticed, forming vascular sinusoids that dissect collagen fibers. Architecture becomes chaotic, when the disease is more aggressive, with undefined vascular spaces.[3] In this case, some immunohistochemical markers are useful in reaching a diagnosis, such as the Von Willebrand factor, *Ulex europaeus agglutinin-1*, laminin, CD31, CD34, vascular endothelial growth factor, and vimentin.[1,3,4] Metastases are not common in the initial examination, although a third of patients develop them, and the lung is the most frequently affected.[3] Currently, there are no standard guidelines for treating skin angiosarcoma. When the tumor is in the initial stage, radical surgical excision constitutes the first therapeutic option and may be accompanied by adjuvant radiation therapy, as the tumor may display clinically undetectable local dissemination.[2] However, when the disease is extensive, radiation therapy or chemotherapy may be considered.[2,5] For metastatic disease cases, cytotoxic chemotherapy is the preferred treatment. Standard palliative chemotherapy for soft tissue sarcoma has been performed with doxorubicin. However, taxanes, especially paclitaxel, stand out as promising agents in treating this class of tumors.[5] ❑

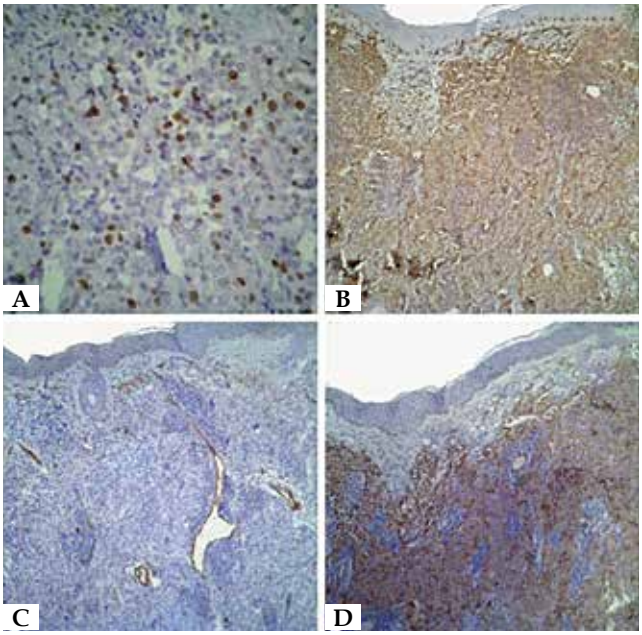

Figure 3: Immunohistochemistry: **A-** Positive vimentin, 200x. **B-** Positive Ki 67, 100x. **C-** Positive CD34, 100x. D- Positive CD31, 100x

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Condyloma acuminata at urethral orifice complicated with hemophilia A*

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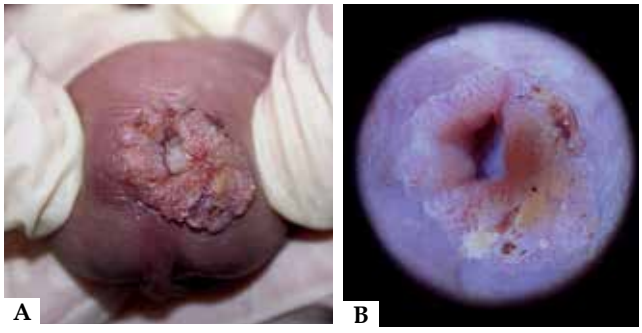
Dear Editor,

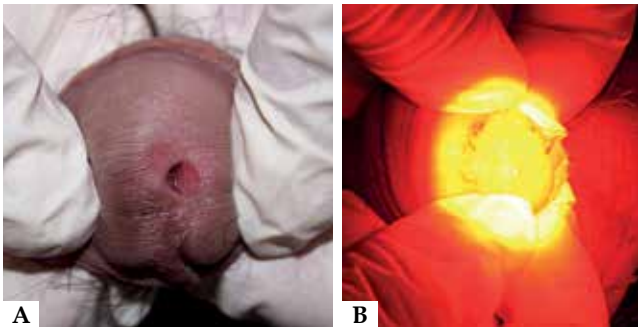
Condyloma acuminata is a sexually transmitted disease caused by the infection by human papilloma virus. Its warts are papillary or cauliflower-like. This report focuses on a case of condyloma acuminata complicated with hemophilia A. To avoid bleeding and infection during the treatment, we made a dermoscopic diagnosis, and performed the treatment with PDT, with a good clinical efficacy. The report is as follows.

A 37-year-old male patient was referred from the Outpatient Department in August 2012. The patient suffered repeated knee joint hematoma, and was diagnosed with hemophilia A by another hospital 20 years ago. He was treated with coagulant factor VIII, cryoprecipitate and frozen plasma in the local hospital. In the past two weeks, the patient was found to have several cauliflower-like excrescences at the urethral orifice, which grew up rapidly and was positive in acetowhite test. HPV-DNA was found to be type 6. The blood test showed WBC 8.07*10^9/L, RBC 5.43*10^{12}/L, Hb 95 g/L, HCT 33.6%, MCV 61.9 fl, MCH 17.5 pg, RDW-CV 21.7%, MCHC 283 g/L, PLT 303*10^9/L, PT 10.7S, APTT-SS 78.2S, APTT-R 2.74. Based on his clinical history, the patient was diagnosed with hemophilia A complicated with condyloma acuminata at internal and external urethral orifice (Figure 1A and 1B).

Hemophilia A is a hereditary hemorrhagic disease that causes coagulation disorders due to the deficiency of coagulant factor VIII. The major symptom of hemophilia A is spontaneous bleeding or non-stop bleeding after a minor injury. Condyloma acuminata (or genital warts) are excrescences on skin caused by the infection with human papillomavirus (HPV), and normally occur at genital or anal areas.[1] Conventional methods to treat genital warts include laser ablation, electrocauterization, microwave, corrosive drugs and destructive therapies, which however can only remove visible warts, and may cause ulcer, bleeding, damage to surrounding normal tissues, pain, infection and scarring. To avoid bleeding, we adopted dermoscopic diagnosis to clearly show the papillary excrescences and vascular characteristics. Considering the physical condition of this patient, we decided to apply 5-Aminolevulinic Acid Photodynamic Therapy (PDT) to treat condyloma acuminata at his urethral orifice. In 5-Aminolevulinic Acid Photodynamic therapy, photosensitizer, which can be selectively concentrated in the condyloma acuminata lesions, is locally applied. When the condyloma acuminata lesion is irradiated with light of 635 nm wavelength, the photosensitizer can produce singlet oxygen, which can cause necrosis of the lesions and slight injury to normal mucosal tissues.[2-3] If the patient with hemophilia A was treated with invasive methods that can



Figures 1: A. 37-year-old male patient found to have cauliflower-like warts at urethral orifice. **B**. Papillary wart was dermoscopic visible, with obvious vascular characteristics



Figures 2: A. The lesion was completely removed after treatment with PDT. **B.** The same condyloma acuminata lesion during photodynamic therapy.

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