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Cutaneous Myxoma Coexisting with an Epidermal Cyst: A Case Report and Brief Literature Review

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Dear Editor:

A solitary cutaneous myxoma (SCM) is a relatively rare tumor. It is clinically characterized by an asymptomatic flesh-colored nodule and histologically by a cystic lesion consisting of sparsely scattered spindle cell with indistinct border against a myxoid background with variable vascular components[1]. In contrast to syndromic myxoma which raises the necessity for systemic evaluation to rule out other conditions such as Carney's complex, non-syndromic myxomas have been less emphasized in the clinical setting, and their pathogenesis has not been well-elucidated.

A 53-year-old Korean male with hypertension, type 2 diabetes mellitus, and a history of cerebral infarction (5 years prior) was admitted to our hospital because of a solitary protruding nodule in the posterior region of his neck for 1 year without any symptom (Fig. 1A). The lesion had been squeezed-out by the patient several times but had continued to recur. A biopsy showed typical histological features of an epidermal cyst (Fig. 1B). However, an ill-defined mucinous stroma staining positive with Alcian blue was observed around the epidermal cyst. A wide excision was performed because of the possibility of a bulky myxoid tumor coexisting with the cyst. A lobulated mass with fibrous septa was found extending to subcutaneous fat (Fig. 1C). A cystic structure showed loosely reticulated cells, and negative S-100 staining without cellular atypia (Fig. 1D). Other macroscopically similar tumors, including myxoid neurofibroma and nerve sheath myxoma, were excluded based on the negative S-100 staining and paucity of mast cells, Meissner's corpuscles, and mitotic activity. No pigmentary disorders such as lentiginosis or blue nevi were observed elsewhere in the body. In addition, echocardiography revealed no atrial myxomas. As the patient had no family history of myxoma, syndromic myxoma was excluded, and he was diagnosed with SCM. He remained stable without recurrence for 4 months after the excision.

Coexistence of non-syndromic SCM and another tumor has been reported uncommonly but steadily. A literature review revealed no predilection for sex, age, or location (Supplementary Table 1). Coexisting conditions were mainly benign adnexal tumors such as pilomatricoma and epidermal cyst. Among patients whose follow-up periods were mentioned, most showed recurrence after the excision.

Abnormal epidermal expression of CD44, a major hyaluronic acid (HA) receptor, induces a change in HA composition of the extracellular matrix in the dermis, causing the development of mucinous tumors and expansion of keratinocyte carcinomas[2,3]. Skin barrier disruption or perifollicular inflammation can act as a direct or indirect stimulus for the dysregulated interaction between CD44 and HA[4,5]. Despite the uncertain temporal relationship between the two different tumors in our case, the incidence or expansion of myxoma is speculated to be influenced by repeated mechanical stress (e.g., squeezing) or

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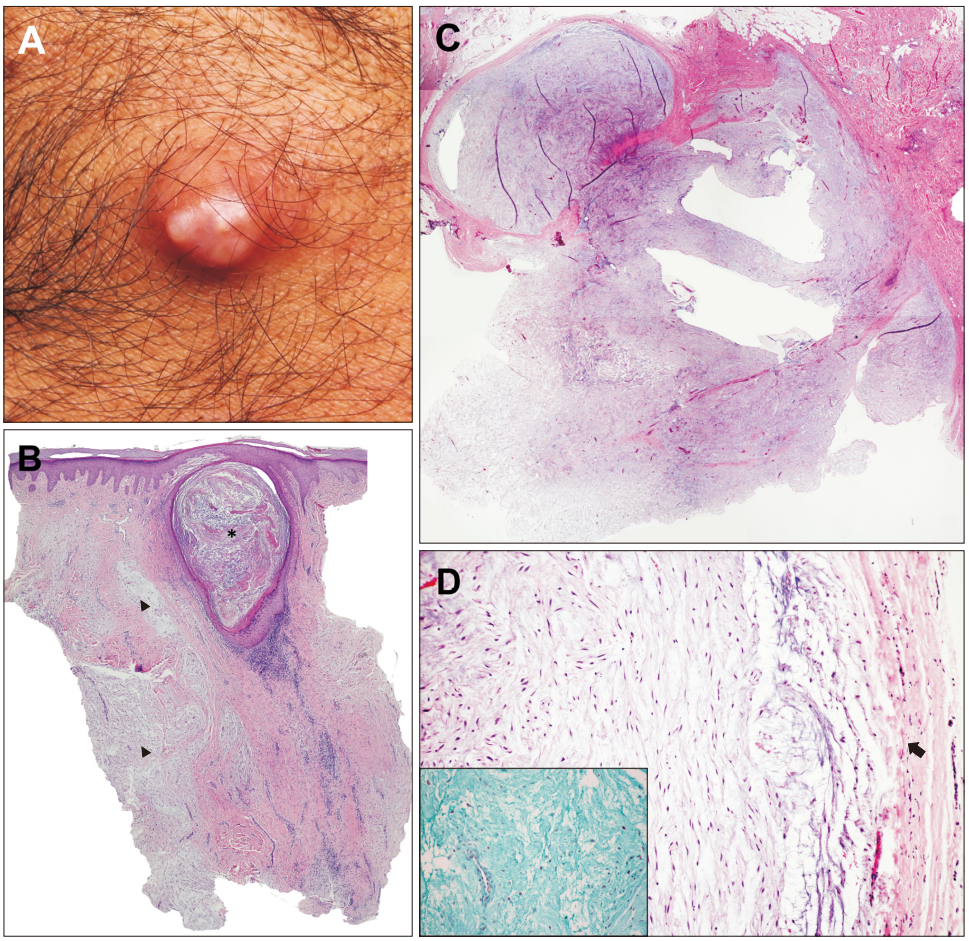

Fig. 1. (A) A solitary asymptomatic soft nodule in the posterior region of the neck. (B) The initial biopsied specimen showed a diffuse multifocal mucinous stroma (black arrowheads) extending to the deep dermis in the periphery of an epidermal cyst (asterisk; H&E, ×40). (C) Subsequent excision of the specimen exposed a lobulated cystic mass containing a myxomatous stroma and fibrotic septa (H&E, ×12.5). (D) Poorly scattered spindle cells without cellular atypia in the myxoid stroma staining positive for Alcian Blue (left corner) (H&E, ×100). Grossly, the tumor is unencapsulated, but its boundary with adjacent fibrotic tissue (black arrow) is well demarcated (H&E, ×100). We received the patient's consent form about publishing all photographic materials.

local epidermal invagination.

In conclusion, we report a case of SCM co-existing with an epidermal cyst and suggested that the coexistence of two tumors is non-negligible, and not just an incidental finding. In cases of myxoma showing atypical clinical manifestation and a tendency for recurrence, the possibility of concurrent tumors should be considered.

SUPPLEMENTARY MATERIALS

Supplementary data can be found via http://anndermatol.org/src/sm/ad-33-591-s001.pdf.

CONFLICTS OF INTEREST

The authors have nothing to disclose.

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Severe Psoriasis Successfully Treated with Brodalumab after Eradication of Hepatitis C Virus with Glecaprevir and Pibrentasvir: A Case Report

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Dear Editor:

Consensus has not been reached on adverse effects of biologics in patients with hepatitis C virus (HCV) infection. However, patients should be examined for HCV infection before biologic therapy and, if administration is necessary in HCV-positive patients, they should be carefully followed-up[1]. Regarding HCV treatment, new direct-acting antiviral agents (DAAs) are extremely effective and the rate of sustained viral response (SVR) is very high[2,3]. Here we report the first case of severe psoriasis successfully treated with brodalumab after the eradication of HCV with glecaprevir and pibrentasvir.

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A 62-year-old Japanese male, who had been diagnosed with chronic hepatitis C and psoriasis for 10 and 2 years, respectively, was referred to us in July 2018. His chronic hepatitis C had been treated with interferon and ribavirin ten years earlier with discontinuation. His psoriasis had been treated with topical corticosteroids and vitamin D3 with limited efficacy. Physical examination revealed scaly erythematous plaques on his back (Fig. 1A), chest, abdomen, and extremities. The psoriasis area and severity index (PASI) score was 16.8. Abnormal laboratory findings were as follows: aspartate aminotransferase (AST) 96 U/L (normal range, 13~30 U/L), lactate dehydrogenase (LDH) 299 U/L (normal range, 124~222 U/L), γ-glutamyl transpeptidase (γ-GTP) 210 U/L (normal range, 13~64 U/L), hepatitis B (HB) core antibody 6.02 signal-to-cutoff (S/CO), HCV antibody 14.20 S/CO, HB virus (HBV)-DNA not detectable, HCV-RNA 6.6 Log IU/ml (1B genotype). After our consultation to hepatologists, his chronic hepatitis C was treated with the new DAAs glecaprevir and pibrentasvir from November 2018 for 8 weeks. At 4 weeks after the treatment began, HCV-RNA value became undetectable and the levels of AST, LDH and γ-GTP returned to normal. After confirming the SVR in February