



FIGURE 1: **A:** severe oral mucositis with hemorrhagic crusts **B:** papules with central necrosis in the pre-sternal region. **C:** involvement in areas of pressure. **D:** significant improvement after suspension of medication and replacement of folinic acid

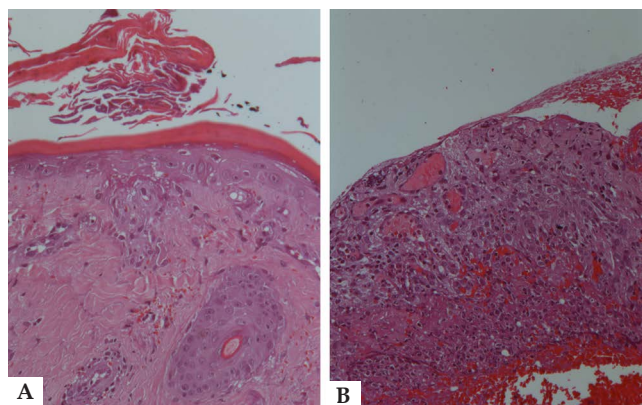


FIGURE 2: Light microscopy with necrosis of epidermis **A:** and oral mucosa **B:** Hematoxylin & eosin, X400

how much of a medication should be given.¹

MTX is an excellent therapeutic option for the treatment of inflammatory diseases, such as rheumatoid arthritis and psoriasis. However, due to its effectiveness and convenient posology, it can be indiscriminately used. Serious morbidity and potential mortality associated with acute toxicity justify the need for adequate guidance by the physicians and regular monitoring of patients receiving this type of therapy. It is of outmost importance that dermatologists are aware of a frequent misunderstanding about the dosage (daily instead of weekly dose). □

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Urban American cutaneous leishmaniasis*

Francisca Regina Oliveira Carneiro¹
 Gabriela Athayde Amin¹
 Lorena de Britto Pereira Cruz¹
 Belkis Azevedo Daher¹

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Dear Editor,

American cutaneous leishmaniasis (ACL) is a dermatozoonosis of wide distribution and great incidence in the Brazilian territory. It is caused by several protozoa of the genus *Leishmania* and is transmitted by the bite of phlebotomine sandflies.¹

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¹ Dermatology Service, Universidade do Estado do Pará (UEPA) - Belém (PA), Brazil.

MAILING ADDRESS:

Belkis Azevedo Daher

E-mail: belkisdaher@gmail.com

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It typically affects individuals who work in forests such as geologists, farmers, miners, and forest technicians. Therefore, it is characterized as an occupational disease. However, over the last years, ACL has been undergoing urbanization.¹

We describe two cases that occurred in the urban area of Belém: a 26-year-old military man, who had been presenting with

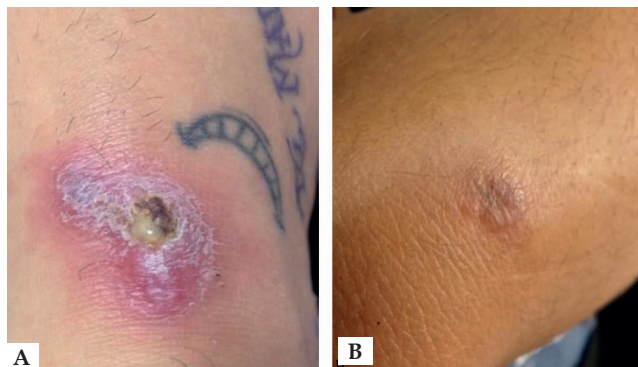


FIGURE 1: A: Erythematous-infiltrated plaque with scaling and central serohematic crust, measuring approximately 3.0 x 1.5cm on the dorsum of the right foot B: Erythematous-infiltrated plaque of approximately 1.5 cm in the right elbow

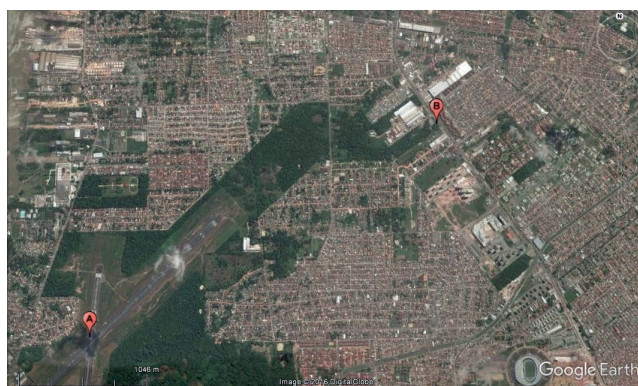


FIGURE 2: Map of part of the city of Belém, Pará. A: Val-de-Cans neighborhood; B: Parque Verde neighborhood. Source: Google Earth

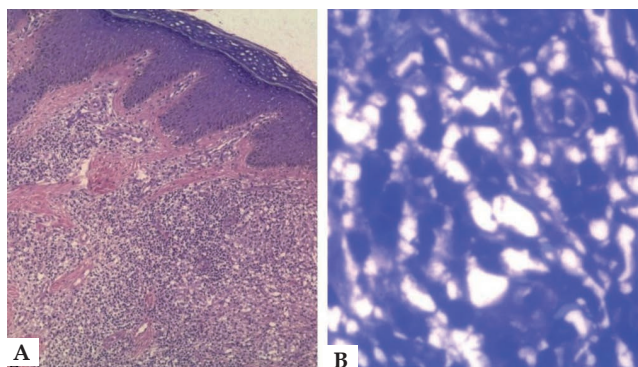


FIGURE 3: A: Hyperplastic epidermis with orthokeratosis, hypergranulosis, irregular acanthosis, and spongiosis on the dermis with moderate inflammatory infiltrate formed by lymphocytes, histiocytes, rare plasmocytes, and eosinophils (Hematoxylin & eosin, X4) B: Leishmania inside macrophages (Hematoxylin & eosin, X40)

an erythematous-infiltrated plaque of approximately 1.5 cm in the right elbow for 8 months; and a 22-year-old female dentist, who had been presenting with an erythematous-infiltrated plaque with scaling and a central serohematic crust, measuring approximately 3.0 x 1.5 cm on the dorsum of the right foot for 5 months (Figure 1).

Both lived in the urban area of Belém. The man lived in the Val-de-Cans neighborhood and the woman at Parque Verde. These neighborhoods are close to each other and they both show forest fragments (Figure 2). The patients denied having gone on recent trips and having been to forests.

They underwent biopsy of the lesions and the histopathological results showed hyperplastic epidermis, with orthokeratosis, hypergranulosis, irregular acanthosis, and spongiosis on the dermis with moderate inflammatory infiltrate formed by lymphocytes, histiocytes, rare plasmocytes and eosinophils, arranged around the superficial capillaries and between the dermal collagen fibers. We observed presence of structures similar to leishmanias in the infiltrate and inside macrophages (Figure 3).

Patients were treated with 15mg Sb⁺⁵/kg/day of N-methyl glucamine for 20 consecutive days, evolving with lesion regression.

Cases of autochthonous ACL in the urban areas of Brazilian municipalities have been described, such as those of two individuals in the Caju neighborhood, in the city of Rio de Janeiro. These cases indicate a change in the epidemiological pattern of ACL.²

The urbanization of ACL probably results from the domestication of the components of its transmission cycle due to deforestation, with the spread of disease-transmitting insects and host mammals to intra or peridomicillary sites.³

A study in a municipality of Minas Gerais indicated rodents of the species *Rattus rattus* and *Mus musculus* (species usually associated with human dwellings) as possible reservoirs of the disease in the urban area, after the detection of specimens infected with *Leishmania brasilienses*.⁴

In a recent survey conducted in Manaus, it was observed that patients with urban ACL often resided near areas of residual forest within the city boundaries.³

The metropolitan area of Belém has been undergoing an accelerated process of urbanization since the middle of the 20th century, which has caused a decrease in natural vegetation and possibly in the fauna of ACL vectors. However, some forest fragments still remain in the city.⁵

A survey conducted between 2014 and 2016 found phlebotomine sandflies infected with *L. (L.) amazonensis* in a forest fragment in the metropolitan area of Belém, which allows us to conclude that forest fragmentation does not prevent the maintenance of the *Leishmania* cycle.⁵

We report these cases to reinforce the importance of continuing with the diagnostic investigation of ACL, even though the epidemiology presented by the patient may not be the classic one. □

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Topical corticosteroid therapy: a treatment option for nevus lipomatosus cutaneous superficialis?*

Rafaella Daboit Castagna¹
Lia Natália Diehl Dallazem²

Ana Maria Benvegnú²
Catiussa Spode Brutti³

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Dear editor,

The nevus lipomatosus cutaneous superficialis (NLCS) is a rare benign hamartomatous tumor.¹⁻³ It presents in two clinical forms: the classic and the solitary. The classic form usually occurs in

childhood and adolescence and is characterized by multiple asymptomatic, soft, cerebriform, pedunculated, yellow or skin-colored papules, nodules or plaques.³ The solitary form is uncommon and usually affects individuals older than 20 years of age; it presents as a single sessile papule or dome-shaped lesion.¹

The treatment option is usually motivated by cosmetic purposes, because there are no systemic consequences nor associated malignant tumors. Surgical excision is an appropriate option if the patient decides to treat.^{1,4} We report an unusual case of classic NLCS, with onset in an atypical age group that had satisfactory clinical response with topical corticosteroid treatment.

Female, 52-year-old patient, smoker, presented with the lesion on the back for almost 2 years. In hot days and with sun exposure, the lesion became itchy with development of erythema and edema. Physical examination revealed a yellow plaque formed by multiple pedunculated and confluent papules, measuring 7 cm x 10 cm, on the right infrascapular region, following the Blaschko's lines, not crossing the median line (Figure 1). Darier sign was negative. Initial differential diagnosis were solitary mastocytoma, neurofibroma, cutaneous leiomyoma and Shagreen patch. A punch n.º 4 biopsy was performed and the histopathology revealed mast cells in the subtle superficial and interstitial perivascular inflammatory infiltrate, suggestive of cutaneous mastocytosis. We prescribed fludrocortidone (0.125 mg/g) cream whenever the lesion became itchy. The patient used the medication almost daily for four months, with improvement of the symptoms and partial involution of the lesion (Figure 2). Despite worsening with heat and sun exposure, the clinical aspect and the course of the lesion were not typical of cutaneous mastocytosis, so we suspected NLCS. A new incisional biopsy was performed (ellipse) and the histopathology revealed mature fat tissue in the dermis, more prominent around the vessels and associated to dermal perivascular and interstitial mast cells – findings there are consistent with NLCS (Figure 3). We opted not to perform surgery due to the regression of the lesion with topical corticosteroid treatment and the lack of symptoms.

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¹ Private Practice – Lages (SC), Brazil.

² Department of Internal Medicine, Universidade Federal de Santa Maria (UFSM) – Santa Maria (RS), Brazil.

³ Department of Dermatology, Hospital Universitário de Santa Maria, Universidade Federal de Santa Maria (HUSM-UFSM) – Santa Maria (RS), Brazil.

MAILING ADDRESS:

Rafaella Daboit Castagna
E-mail: lellacastagna@hotmail.com

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FIGURE 1: Subtly yellow plaque, made by multiple pedunculated and confluent papules on the right infrascapular region