

A specimen from the soft mass lesion on the trunk revealed encapsulated, lobulated and largely univacuolated mature adipocytes. The lobules were divided by delicate fibrous septa containing thin-walled vessels. The histopathological diagnosis was nodular and thickened port-wine stain and multiple lipomas. The thickened PWS plaque was treated with three passes of a CO₂ laser in the ultrapulse mode (0.5 J, 5 W, 3 mm spot size).

We describe a patient with a nodular and thickened port-wine stain accompanied with multiple lipomas and oral mucosa malformation. This suggests a multigermline field defect, perhaps mediated by somatic mutation. Pulsed dye laser (PDL) is generally considered to be the gold standard for PWS therapy, often with very satisfactory responses in early macular lesions. The decreased sensitivity of thickened stains to PDL may be not only because of an increase in the depth of the ectatic vasculature, but also because of the difference origins of the non-vascular elements in the lesions [3-6]. The reported case shows that, in addition to the vascular nature, both ectodermal and mesenchymal abnormalities may be involved in PWSs, and care is therefore required to avoid a misdiagnosis of a benign soft tissue neoplasm. Also, because port-wine stains can be progressive, treatment should be done early to prevent cobbling of the skin and thickening and darkening of the stain. ■

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Ulcerous skin lesions in Carpal Tunnel Syndrome

Carpal tunnel syndrome (CTS) is the leading cause of acroparaesthesia in upper limbs and the most common entrapment neuropathy [1-4]. Clinically, CTS is characterised by the insidious onset of neurological manifestations, predominantly at night, with tingling and numbness in the area of the thumb, forefinger and middle finger. As the condition progresses, it becomes difficult to grasp or to clench the fist, with pain in the hand that may spread to the elbow, with atrophy of the thenar muscles and reduced pain in advanced stages.

We report four cases of CTS diagnosed in our dermatology clinic, in which the clinical features were predominantly of a cutaneous rather than neurological nature, all with skin ulcerations on the forefinger, and acro-osteolysis in one case. The first patient was an 87-year-old woman with a 2-month history of a painless, non-suppurative, ulcerated, acral lesion on the tip of her left forefinger (figure 1). The second patient was a 73-year-old man with 5-month history of a small non-suppurative ulcer on the distal phalanx of the left forefinger, numbness of the thumb and forefinger. The third patient was a 79-year-old man with an 8-month history of a painful ulcer, with necrotic eschar on the surface, located on the distal left forefinger. He reported nocturnal

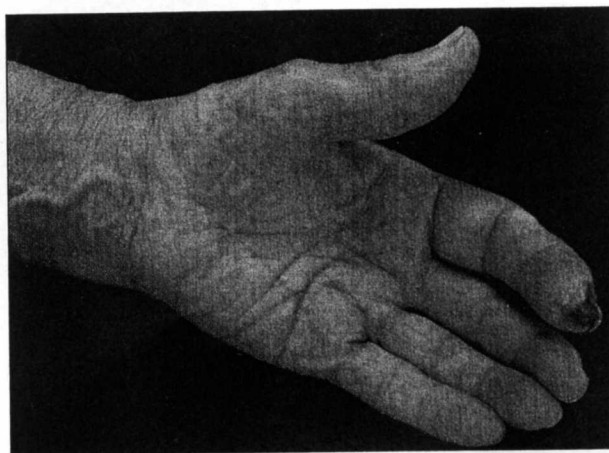


Figure 1. Non-suppurative necrotic ulcer on the tip of the left forefinger with atrophy of the thenar eminence and sclerotic and swollen skin.

paraesthesia with numbness of the left hand and hypaesthesia of the first three digits. Radiography demonstrated acro-osteolysis of the fingertip. The fourth patient was an 83-year-old woman with a 6-month history of difficulty in sewing and a 2-month history of a non painful ulcer on the tip of her right forefinger. Thumb opposition and grip were weak in her right hand with numbness of the thumb, forefinger and middle finger.

All four patients described here might represent cases of idiopathic origin, as no history of trauma or evidence of other systemic or local diseases were detected. Suspected CTS was confirmed by electroneurography, which demonstrated severe axonal degeneration of the median nerve and severely diminished conduction. The patients were referred to the traumatology department, where they underwent decompression of the median nerve followed by rehabilitation treatment. At subsequent check-ups ulcers are in resolution or are easier to manage and occur less often.

Skin lesions in connection with CTS are uncommon and are seen in severe cases with a long history, in which the fibres of the median nerve are severely damaged. There are few references to this condition in the dermatological literature, although subtle skin lesions are described in up to 20% of cases of CTS [3-5]. The most typical findings in advanced CTS are erythema and oedema of the fingers, bullous lesions or small foci of necrosis, acral vasomotor abnormalities (anhidrosis, swelling, Raynaud's phenomenon), sclerodermiform changes, nail dystrophy and mutilations. Distal necrotic lesions are probably caused by poor vasa nervorum function in the distal arterial vascularisation. Impaired thermalgesic sensitivity, and exposure to mechanical and thermal microtrauma may contribute to the onset of the lesions [3]. Surgical decompression of the median nerve improved symptoms in 60% of cases reported in the literature [3]. At this stage, the aim of treatment is to cure the blisters and ulcerations, or reduce the frequency at which they occur, and resolve the secondary problems of infections and acro-osteolysis [6].

Dermatologists should be alert to this syndrome, which features little in most dermatology textbooks. It should always be suspected in patients with ulcerous or necrotic lesions on the tips of the thumb, forefinger or middle finger. This syndrome is easily diagnosed if the possibility is not overlooked, and the prognosis of the lesions depends on early diagnosis and prompt treatment. ■

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Lipoma in the superficial infrapatellar bursa

Lipomas are the most common form of soft tissue neoplasm and bursitis is an ordinary orthopedic disease; however, an isolated lipoma in the bursa is an extremely rare type of tumour. To our knowledge, no case of isolated lipoma in the bursa has been reported in the English literature. Here, we report a lipoma in the superficial infrapatellar bursa of the knee.

A 64-year-old Japanese woman visited our clinic for treatment of a subcutaneous tumour on the front of the right knee (*figure 1A*). The lesion had been present for 4 years and had enlarged in the 4 months before her visit. No history of trauma to the right knee was present. Clinical examination revealed an immobile, smooth-surfaced, elastic-hard, painless mass measuring 4 cm in diameter. Ultrasonography showed a high-echoic mass measuring 1.9 cm × 0.8 cm, with a low-echoic area of about 3 cm around it. Magnetic resonance imaging (MRI) of the mass revealed high signal intensity on T1- and T2-weighted images, and low signal intensity on fat-saturated T2-weighted images (*figure 1B, arrow*). The presence of liquid around the mass was suggested, because of the high signal intensity around the mass on fat-saturated T2-weighted images. No connection with the joint was detected. Treatment involved surgical removal of the tumour under local anaesthesia. The tumour had a well-defined capsule with accumulated bloody effusion. An elastic-hard, yellow-coloured mass was present inside the capsule (*figure 1C*), and the mass was connected to the synovial capsule by a stalk. Histopathological examination revealed the origin of the oval mass from the lipoma and that of the capsule with lining from the bursa (*figure 1D*). The oval mass was composed of mature adipose cells covered by a thin fibrous layer. The capsule wall had fibrin deposition, lymphocytic infiltration, fibroblast proliferation and capillary formation (*figure 1E*). The histopathological findings were compatible with a lipoma in the bursa.