reported in most patients died of melanoma progression or rebleeding within a few months after the onset of rupture.

As rupture of hepatic metastasis of malignant melanoma is very rare, the correct diagnosis may be delayed, resulting in rapid fatal outcomes for affected patients. Therefore, physicians should keep such a rare event in mind when treating patients with hepatic metastases of melanoma showing rapidly progressive anemia and abdominal pain.

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Authors' contributions

Shohei Igari: Designed the study, performed the research and contributed to the analysis and interpretation of data, wrote the initial draft of the manuscript, and read and approved the final version of the manuscript.

Toshiyuki Yamamoto: Designed the study, and assisted in the preparation of the manuscript.

Miyuki Yamamoto: performed the research and contributed to the analysis and interpretation of data, read, and approved the final version of the manuscript.

Nobuyuki Kikuchi: Performed the research and contributed to the analysis and interpretation of data, read, and approved the final version of the manuscript.

Mikio Ohtsuka: Performed the research and contributed to the analysis and interpretation of data, assisted in the preparation of the manuscript, read, and approved the final version of the manuscript.

Conflicts of interest

None declared.

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Benign cephalic histiocytosis: exuberant manifestation in an infant☆

Dear Editor,

Histiocytoses are rare diseases resulting from the proliferation of cells derived from dendritic cells or macrophages. Clinical manifestations vary from benign lesions to severe, disseminated forms. The 1987 classification suggested the existence of three large groups: histiocytosis derived from Langerhans cells, non-Langerhans and malignant histiocytosis.[1] However, a new, revised classification system consists of five groups of diseases. Group L: Langerhans histiocytosis, Group M: Malignant histiocytosis, Group R: Rosai-Dorfman disease and non-cutaneous non-Langerhans histiocytosis, Group H: Hemophagocytic lymphohistiocytosis and macrophage activation syndrome, and Group C which includes non-Langerhans histiocytosis located in the skin and mucous membranes, including benign cephalic histiocytosis (BCH).[2] BCH is rare, occurs in the first three years of life, and is self-resolving, with lesions appearing mainly in the cephalic segment. The case reported herein describes a female infant, aged one month and 21 days, presenting rapidly evolving lesions for ten days. On examination, the patient was in good condition, with isolated or confluent erythematous-violaceous macules and papules, particularly affecting the upper third of the face and isolated lesions on the cervical and trunk regions, and absence of acral or mucosal lesions (Fig. 1). The initial hypotheses were

☆ Study conducted at the Faculty of Medicine, Universidade Estadual Paulista, Botucatu, SP, Brazil.

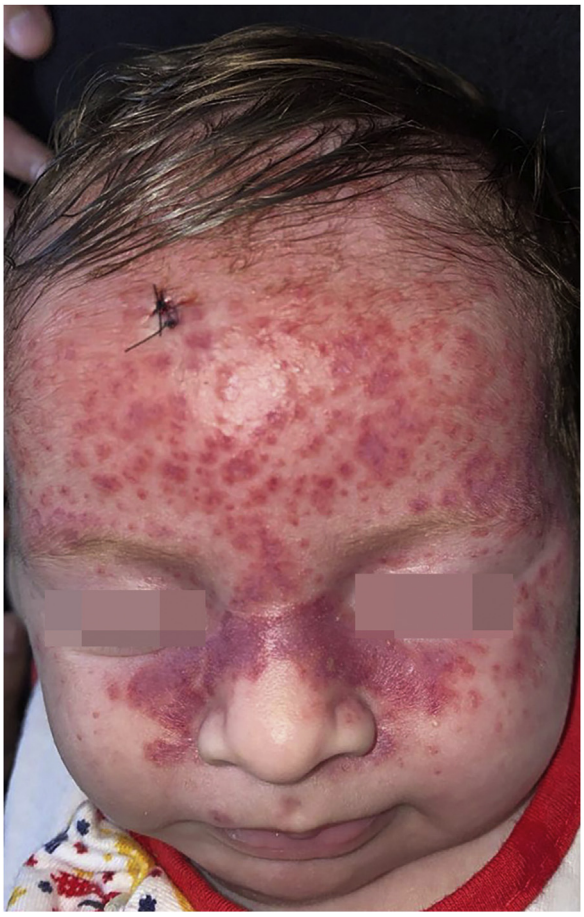

Figure 1 Numerous erythematous-violaceous macules, papules, isolated or confluent, particularly affecting the upper third of the face.

benign cephalic histiocytosis or Hashimoto-Pritzker histiocytosis (HPH). Histopathology showed a diffuse histiocytic infiltrate in the superficial papillary dermis up to the middle portion of the reticular dermis of cells with an oval nucleus and clear cytoplasm (Fig. 2). Immunostaining was positive for fascin and CD68 and negative for CD1a and S100, characterizing a non-Langerhans histiocytosis (Fig. 3). Head, lung and abdominal computed tomographic investigation was negative, confirming the diagnosis of BCH. The approach was to reassure the parents, prescribing hydrocortisone and periodic monitoring.

Patient evolution showed an increase in lesions and expansion of the affected area. However, on the 50th day of follow-up, the lesions appeared to be resolving and on the 60th day there was practically complete resolution (Fig. 4).

BCH was described by Gianotti et al. in 1971[3] and an estimated 70 cases were described in the English-language literature by 2017.[4] The lesions appear around the 2nd to the 6th month of life and are located on the face and cervical region, rarely affecting the scalp. It can also affect the trunk and roots of the limbs.[5] They have an erythematous, or erythematous-violaceous color, are either macules or papules, and may converge and increase in number and area until stabilizing. Spontaneous regression can occur up to the 50th month of age. The differential diagnosis, in addition to HPH, is made with juvenile xanthogranuloma (JXG) and mastocytosis. The clinical aspects and negative immunostaining for CD1a and S100 ruled out HPH. The absence of yellow-orange color, lesions practically restricted to the face and histopathological absence of Touton giant cells ruled out JXG. Mastocytosis, a more distant hypothesis, was excluded due to the clinical appearance, absence of Darier sign and absence of mast cell aggregates on histopathology. There are isolated reports of an association between BCH and JXG and even the appearance of diabetes insipidus in two patients, at some time after dermatological resolution.[2,4] Therefore, long-term monitoring must be maintained.

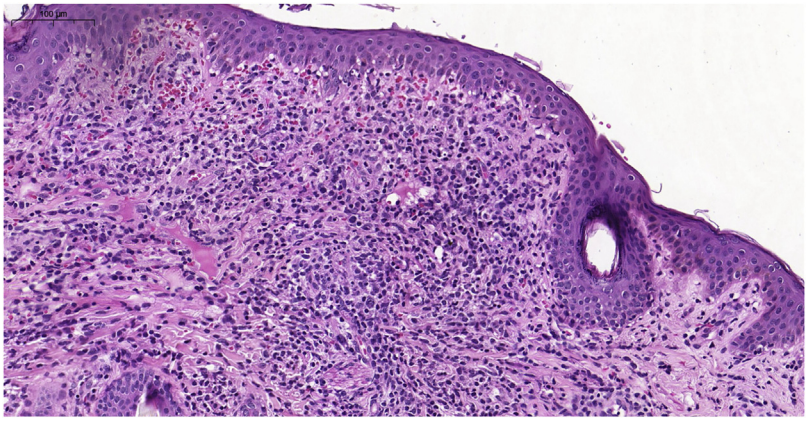

Figure 2 Histopathological examination showing a diffuse histiocytic infiltrate, in the superficial dermis up to the middle portion of the reticular dermis.

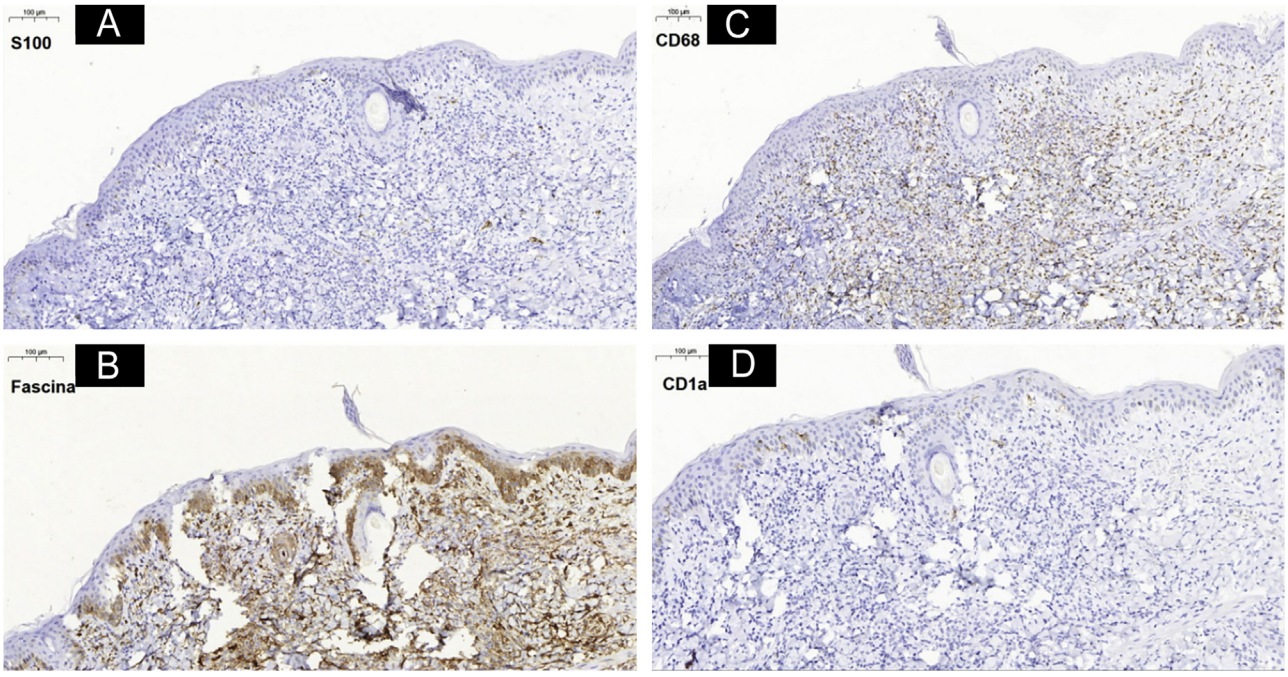

Figure 3 Immunohistochemistry analysis showing positivity for markers (3B) fascin and (3C) CD68 and negativity for (3A) S100 and (3D) CD1a.

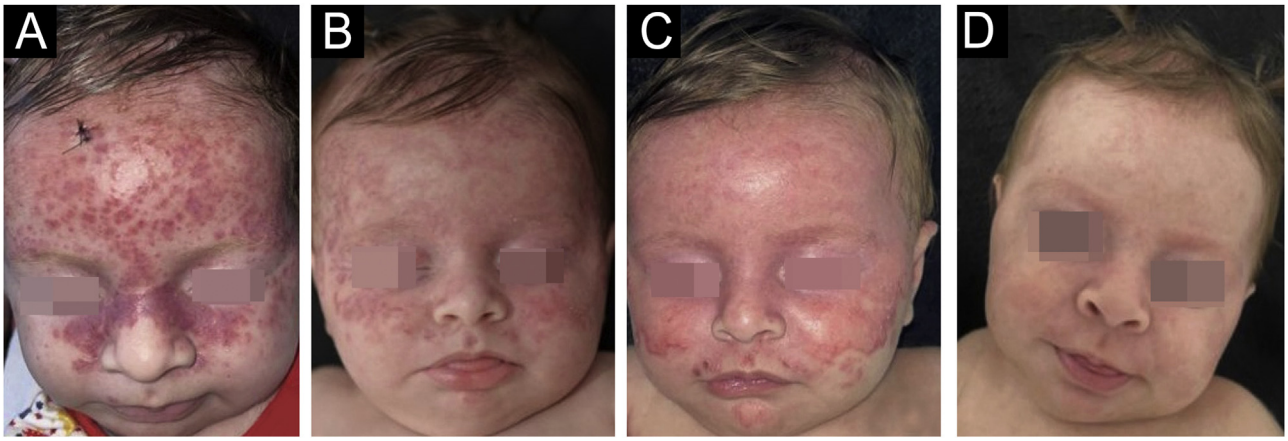

Figure 4 (A) Infiltrated reddish macules and papules, mainly on the face, without involvement of acral areas, mucous membranes or internal organs. (B–D) Evolution of the lesions during the follow-up, on the 22nd, 36th and 50th days, respectively.

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Authors' contributions

Ana Flávia Teixeira de Abreu: Design and planning of the study; drafting and editing of the manuscript; collection, analysis and interpretation of data; effective participation in research orientation; intellectual participation in the propaedeutic and/or therapeutic conduct of the studied cases; critical review of the literature; critical review of the manuscript; approval of the final version of the manuscript.

Rebecca Perez de Amorim: Drafting and editing of the manuscript; collection, analysis and interpretation of data; intellectual participation in the propaedeutic and/or therapeutic conduct of the studied cases; critical review of the literature; critical review of the manuscript.

Pedro Marciano de Oliveira: Drafting and editing of the manuscript; collection, analysis and interpretation of data; intellectual participation in the propaedeutic and/or therapeutic conduct of the studied cases; critical review of the literature; critical review of the manuscript.

Marcelo Padovani de Toledo Moraes: Drafting and editing of the manuscript; collection, analysis and interpretation of data; intellectual participation in the propaedeutic and/or therapeutic conduct of the studied cases; critical review of the literature; critical review of the manuscript.

Silvio Alencar Marques: Design and planning of the study; drafting and editing of the manuscript; effective participation in research orientation; intellectual participation in the propaedeutic and/or therapeutic conduct of the studied cases; critical review of the literature; critical review of the manuscript; approval of the final version of the manuscript.

Conflicts of interest

None declared.

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Cutaneous plasmacytoma: a rare manifestation of multiple myeloma☆

Dear Editor,

Cutaneous metastases result from the spread of a tumor to the skin through lymphatic or vascular embolization, direct implantation during surgery, or involvement of the skin through contiguity. Studies indicate a frequency of 0.7%-10.4%, mainly secondary to visceral neoplasms.[1] The primary neoplasms most often associated with skin metastasis include breast cancer, lung cancer, and melanoma.[2] There are few reported cases of cutaneous metastasis from multiple myeloma (MM), the main topic in this case report. Skin involvement associated with MM occurs in less than 10% of cases.

Due to the rarity of this manifestation, as well as the importance of its correct diagnosis, the present report describes a patient with MM and cutaneous metastasis after disease recurrence.

A 49-year-old female patient had been diagnosed with MM 12 years before. She underwent several treatments, including a bone marrow transplant. She had a painless lesion on her right leg that had been developing for three months. She had a history of excision of a tumor in the right tibia with prosthetic reconstruction in the previous year. On examination, she had two well-defined, erythematous tumors with regular contours, located on the right pre-tibial region, measuring up to 3 cm (Fig. 1). At the site of the orthopedic prosthesis scar, she had an erythematous, hardened, and painless nodule measuring approximately 2 cm, adhered to deep planes (Fig. 1). The pathological analysis of an incisional biopsy was compatible with a

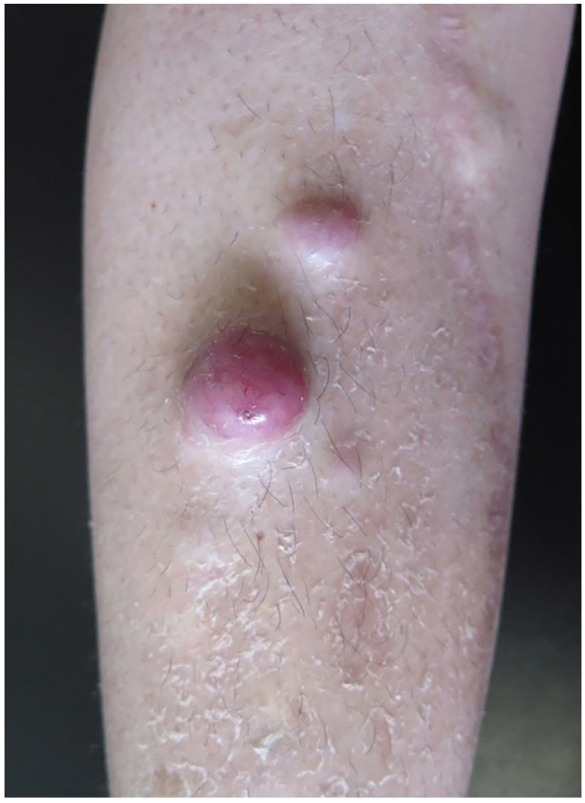

Figure 1 Erythematous tumors on the right pre-tibial region.

☆ Study conducted at the Pontifícia Universidade Católica de Campinas, Campinas, SP, Brazil.