## Superficial acral fibromyxoma*

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Dear Editor,

Superficial acral fibromyxoma (SAF) is a rare slow-growing mesenchymal tumor that is commonly located in the periungual and subungual regions of the fingers and toes.[1] We report the case of a 71-year-old man, who has been progressing for a year with an asymptomatic lesion in the left hallux, with progressive enlargement. At dermatological examination, there was a smooth and well-delimited surface tumor, fibroelastic consistency, painless to palpation, measuring approximately 3cm, located in the left hallux (Figure 1).

In view of the clinical picture, the diagnostic hypotheses of eccrine poroma or onychoblastoma were made. Complete surgical excision of the lesion was performed (Figure 2), with a later histopathological study, which demonstrated a well delimited fibromyxoid neoplasm covered by acanthotic epidermis and hyperkeratosis, showing in the dermis elongated, spindle-shaped neoplastic cells without atypia, with a richly vascularized myxoid stroma, consistent with the diagnosis of superficial acral fibromyxoma. An immunohistochemical study with positivity for CD34 and negativity for the markers S100, Desmina, CK 40 and 48, smooth muscle actin and mucin were also performed (Figure 3). Patient remained in periodic follow-up, without recurrence of the lesion after six months of postoperative period. SAF is a rare mesenchymal neoplasm that typically occurs in the digits of middle-aged adult men, more frequent in the chirodactyls, initially described by Fetsch et al. in 2001. It is a tumor characterized clinically by a solitary nodule, sometimes lobulated, of benign behavior, but which can persist or recur if it is excised in an inadequate manner, being recommended the complete excision of the lesion and postoperative follow-up.[2,3] Nail bed is involved in 50% of the cases, and can rarely have a history of trauma preceding the onset of the lesion. Less frequent locations have already been described as palmar, calcaneal, ankle and thigh regions. Histopathological study reveals a moderately circumscribed unencapsulated tumor located in the dermis and extending to the subcu-

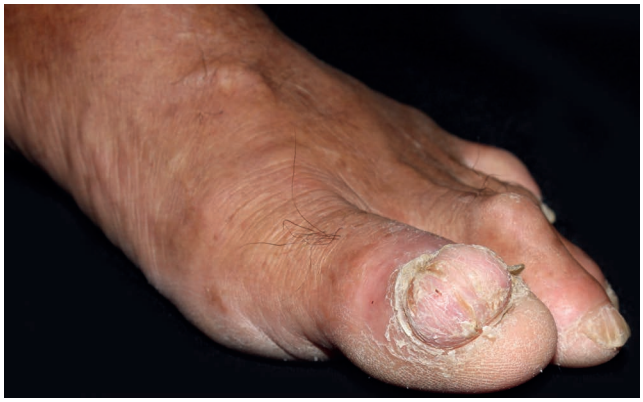

**Figure 1:** Smooth, well delimited surface tumor of fibroelastic consistency, painless to palpation, measuring approximately 3cm, located in the left hallux

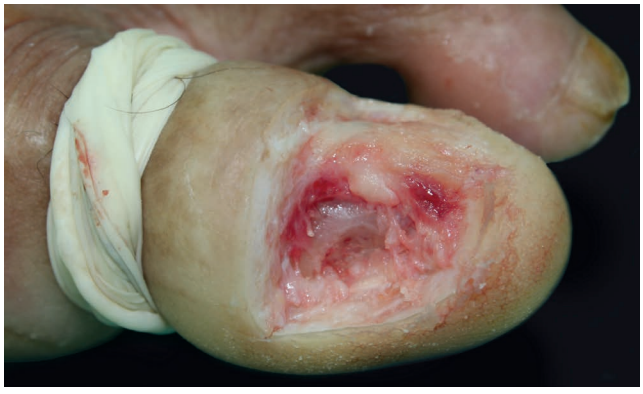

**Figure 2:** Surgical removal of the lesion

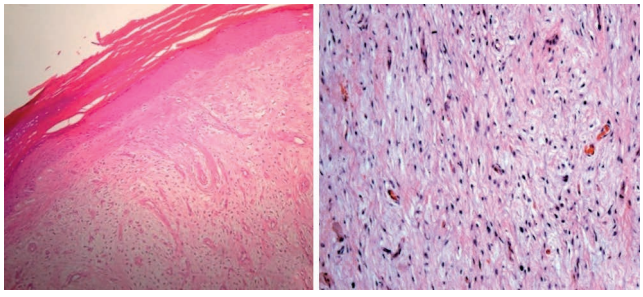

**Figure 3:** In hematoxylin-eosin staining, a well-delimited fibromyxoid neoplasia covered by acanthotic epidermis and hyperkeratosis was observed. In the dermis, elongated, spindle-shaped neoplastic cells were present, with no atypia with a richly vascularized myxoid stroma. Immunohistochemical study revealed positivity for CD34 (Hematoxylin & eosin X100)

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taneous tissue. There is proliferation of fibrobasto-like spindle cells embedded in myxoid collagen stroma.

Tumor cells demonstrate immunoreactivity for CD34, CD99, vimetin, and the results of the epithelial membrane antigen are still inconsistent.[4] Radiological studies may reveal underlying bone erosions and fine needle cytology shows a cluster of loose spindle cells in the myxoid material. Malignant transformation, although rare, is possible.[3,4] Differential diagnosis of SAF should be made with nail/periungual fibroma, acquired digital fibrokeratoma, low-grade fibromyxoid sarcoma, dermatofibroma, superficial angiomyxoma, and myxoid neurofibroma. Treatment of choice is extensive surgical resection and periodic follow-up after excision is advisable, as recurrence rate may range from 10% to 24%. This recurrence has been associated with incomplete resection.[2] Mohs surgery has become a promising alternative due to greater control of the margins, reducing the possibility of recurrence and satisfactorily preserving tissues adjacent to the tumor.[5] SAF, although rare, should be included in the differential diagnosis of tumors involving chirodactyls and toes. ❑


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## Grade III hand-foot skin reaction induced by sorafenib*


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**Dear Editor:**

Human cancer rates have increased in the last years. Although the effects of current treatment methods unfortunately include mutilation (surgery), radiation (radiotherapy), and poisoning of the body (chemotherapy), they remain the most effective weapons to fight the disease.

Sorafenib is a multikinase inhibitor that targets Raf, vascular endothelial growth factor family (VEGFR-2 and VEGFR-3), platelet-derived growth factor-β, Flt-3, and c-Kit, inhibiting molecular pathogenesis, angiogenesis, and tumor cell proliferation. Although it represents the standardized treatment for advanced hepatocellular carcinoma nowadays, a number of case reports on its side effects have been published. Recent guidelines of the European Association for the Study of the Liver (EASL) and the American Association for the Study of Liver Diseases (AASLD) recommend sorafenib as the first-line therapy for patients with advanced hepatocellular carcinoma.[1]

Unfortunately, as with other cytostatic drugs, side effects are often associated with this drug. Hand-foot syndrome has been previously reported as an adverse event during sorafenib therapy. For example, in a recent Chinese study, 68.7% of 83 patients treated with sorafenib for metastatic renal cell carcinoma developed hand-foot syndrome. In a Japanese study, 45.0% of 241 patients diagnosed with advanced hepatocellular carcinoma developed this syndrome.[2,3]

We present the case of a 78-year-old female patient diagnosed with hepatocellular carcinoma who was referred to our dermatology unit due to intense redness and pain on both palms,


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