the negativity of CD34 and desmine. The patient was treated by radical surgery (superior lobectomy) and four courses of adjuvant chemotherapy with adriamycin. When the sarcoma relapsed, the patient had similar biological parameters regarding HIV infection. Seven months after lung surgery, the patient was still disease free.

MFH is one of the most frequent soft tissue sarcomas and usually affects adults between the ages of 50 and 70. This tumour involves mainly skeletal muscles of the limbs and retroperitoneum. Primary cutaneous MFHs are much less common. The prognosis of the latter subset is related to tumour size and histological grading. Local recurrence and distant metastasis occur in about 26 and 32% of patients, respectively. The most common site of metastasis is the lung. The mean delay between primary tumour and metastasis is 12–14 months. Classical therapy of primary tumour consists of wide surgical excision.2

Epidemiological data reveal an increased risk for sarcoma, mainly leiomyosarcoma, in HIV-infected patients, especially in children.3,4 Leiomysarcomas occurring in an HIV-infection setting are most often related to Epstein-Barr virus infection.4 Other sarcomas are otherwise scarce, except for Kaposi’s sarcoma.5 Visceral sarcoma of other histological subsets has only rarely been described in HIV-infected patients: one case of liver fibrosarcoma in an African child6 and a case of a MFH of the small bowel.7 Cutaneous sarcomas have been described as dermatofibrosarcoma protuberans in two cases.8 To our knowledge, primary cutaneous MFH has never been reported in a patient with HIV. This association may be fortuitous considering the respective frequencies of the two afections, but the involvement of immune failure in sarcoma development can not be ruled out. Indeed, in animal models SV40-infected cells might trigger the development of MFH.9 A role for a virus has never been demonstrated in human MFH but remains possible according to this experimental report, considering the immunodeficiency associated with HIV infection. Conversely, the metastatic evolution observed in our patient seems to be related more to the large size of the primary tumour than to the immune failure itself, as the delay of metastasis appearance and metastasis to the lung are usual for this subset of tumour.2

References

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Delayed foreign body granuloma secondary to an abandoned cardiac pacemaker wire

Editor
An 83-year-old man with a pacemaker in the left upper chest presented with a nodule on the right upper chest area that had appeared several years before. Past medical history disclosed an atrioventricular heart block and right pacemaker implantation in 1990. Due to secondary infection in 1995, the pacemaker was removed and a new device was placed on the left chest area. Five years later a nodule developed on the right chest; this lesion presented recurrent inflammatory episodes that were treated with oral antibiotics. Physical examination disclosed an ulcerated papulonodule, 0.5 cm, on the right infradracavicular area (fig. 1), located below a surgical scar of a pacemaker removal site. Histopathological examination disclosed a diffuse dermal inflammatory infiltrate with a mixed acute
and subacute component, and abundant plasma cells. Bacteriological cultures were negative. A chest X-ray film showed a dense right paratracheal image (fig. 2a). During excision of the lesion a fistulous tract was identified, and foreign material in the subcutaneous fat tissue was found that corresponded to an old pacemaker wire tip (fig. 2b). Patch tests with a metal and the European standard series of allergens were negative. No clinical recurrence has been noted after a 1-year follow-up.

Replacement of pacemakers is a frequent procedure in cardiology, but their removal can be difficult. Complications include invagination of the wall ventricle, laceration of the myocardium or tricuspid valve, ventricular arrhythmia, rupture of the electrode, migration of the wire, and haemopericardium. As most patients have a good tolerance to retained pacemaker leads, and the reported risk of complications is considered to be low, a common practice is to leave non-infected leads in place. Nevertheless, the frequency of complications with retained non-infected leads is quite variable (3–30%). Adverse effects secondary to retained pacemaker wires include lead migration, ventricular loop formation, muscular excitation, sensing failure, pulmonary thromboembolism, haemopericardium, pleural retractions and cutaneous lesions. In order to prevent these risks, some authors have proposed cutting the abandoned leads back, and suture them to the underlying fascia. Removal of abandoned leads is usually reserved for patients with life-threatening complications. Other indications for pacemaker lead extraction are the recurrence of local infection and/or septicaemia.

Cutaneous lesions developing as a consequence of abandoned ventricular leads have received little attention in the dermatological literature. Cutaneous erosions, draining sinus formation, foreign body granulomas, and local infections have rarely been reported. In 1980, Mittapalli reported draining sinuses, resulting from a permanent electrode eroding through the dermis. Matwiyoff et al. described a patient with a foreign body granuloma on the chest resulting from a transdermal migration of a retained epicardial pacing wire; and Kootiratrakarn et al. described the development of a mixed cell granuloma on the chest wall, adjacent to the lead-electrode parts of a permanent cardiac-pacemaker. In all these cases, a definitive resolution was achieved after removal of the foreign body. Faced with a cutaneous lesion coincident to the area of a pacemaker scar, the presence of an underlying abandoned lead should be considered. Regular follow-up and close co-operation between dermatologists, cardiologists and cardiothoracic surgeons are of major importance in order to establish an early diagnosis and to adopt adequate therapeutic approaches.

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References

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Follicular involvement in porokeratosis

Editor

Porokeratosis is a disorder of keratinization characterized by annular plaques with normal or atrophic centres surrounded by a keratotic ridge that corresponds histologically to the cornoid lamella.1 It was first described by Mibelli in 1889 and since then many other clinical variants have been described,2,3 such as disseminated superficial actinic porokeratosis (DSAP).1,4,5

Disseminated superficial actinic porokeratosis A 43-year-old white housewife, with blonde hair and blue eyes, reported the appearance of lesions on her arms and legs over the past few years, that made her skin rough. Her mother, a brother and her daughter had similar lesions. Dermatological examination revealed characteristic porokeratotic lesions with keratotic ridges on sun-exposed areas; inside the ridge there were keratotic papules (fig. 1a) and other areas with only the keratotic papules with the same distribution were also observed. Biopsies of a papule and from a keratotic ridge were performed and the cornoid lamella was identified in both. In the papule, the parakeratotic lamella had a follicular localization (fig. 2a). Scanning electron microscopy of a papule was performed and a keratotic plug surrounding a vellus hair could be observed (fig. 2b).

Porokeratosis of Mibelli A 45-year-old white woman, dark-haired with brown eyes, had presented over the past 5 years with three lesions, with slow centrifugal growing, localized on the back of the left hand, left ankle and right arm. Dermatological examination showed desquamative plaques with follicular accentuation inside a hyperkeratotic edge (fig. 1b). Two of them were larger than 5 cm in diameter. Histopathological examination showed parakeratosis inside the hair follicle.

Porokeratosis of Mibelli (PM) was the first described type of this peculiar group of dermatoses, which have clinical and histological similarities. The DSAP is the most common type of porokeratosis. It is inherited in an autosomal dominant trait with a reduced penetrance at a young age.4 Clinical features can vary among the different members of a

fig. 1 (a) Irregular keratotic edge with five punctate lesions. (b) Typical lesion of porokeratosis of Mibelli with follicular accentuation on the back of the left hand.