Histopathologically the tumor is sparsely to moderately cellular and predominantly composed of stellate and spindle-shaped cells, embedded in a loosely collagenized matrix with scattered vessels of varied caliber.[3] The neoplastic cells are usually immunoreactive for vimentin, desmin, α-smooth muscle actin, and estrogen and progesterone receptor.

Although pedunculated lesions may be treated by only a local excision,[5] most reports conclude that wide surgical excision is the main treatment of choice.[2,3] It should be noted that total excision is sometimes difficult, because: (1) the tumor frequently expands widely into parametrial and intra-abdominal spaces with an appearance localized within skin; (2) the tumor is often indistinguishable from the adjacent tissues; and (3) preservation of the uterus is desirable when the patient is of reproductive age. Therefore, preoperative internal evaluation and regular postoperative follow-up such as biannual pelvic magnetic resonance imaging may be preferable, although our patient declined further investigations.

To our knowledge, very few cases of AAM have been published in the dermatology field of the English-language literature. Dermatologists should consider this rare neoplasm in their differential diagnoses when they see a patient with soft, subcutaneous vulval tumor like lipoma, neurofibroma, or Bartholin's cyst.

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Granulation tissue in palpebral conjunctivae associated with acitretin therapy

To the Editor: We would like to report the development of excess granulation tissue during treatment with acitretin on palpebral conjunctivae. This is a unique complication because this kind of reaction normally appears on nail sulcus or on acne lesions.

A 33-year-old male who had been suffering from psoriasis vulgaris for 2 years had red, scaly, disseminated plaques covering a large area of his body. Because of the unresponsiveness to the previous treatment (topical corticosteroids and tar), we started oral acitretin at the dose of 30 mg/day. After 60 days of therapy, a clinical improvement was observed, but the patient complained of watering eyes, erythema, and edema near the eyes (Fig 1). The patient did not use contact lenses or have a history of eye trauma. He also did not have signs of ophthalmic rosacea (blepharitis). Upon examination, an excess of granulation tissue was noted on palbebral conjunctivae bilaterally (Fig 2), which we believe to be related to the therapy and thus the use of acitretin was stopped. A biopsy specimen was obtained and stained with hematoxylin-eosin. Microscopic examination revealed that the dermis contained a dense mixed perivascular cellular infiltrate with numerous plasma cells and that the dermis contained markedly oedematous stroma with numerous small blood vessels, consistent with granulation tissue. Internal structures of the eyes were not evaluated. Forty days after the withdrawal of the drug, the lesion resolved spontaneously.

Excess granulation tissue may occur, especially at sites of nail sulcus in patients taking etretinate and in healing cystic acne lesions in patients taking isotretinoin, mainly on the neck, shoulders, upper arms, chest, back, and buttocks.[1] There have been some reported cases of granulation tissue in unusual places during retinoid therapy: the occurrence of multiple facial pyogenic granuloma—like lesions has been reported in a patient with severe cystic acne treated with oral isotretinoin[2]; a psoriatic patient developed granulation tissue in the area of minor trauma on the lower leg after long-term oral etretinate therapy[3]; the development of multiple similar lesions on both thighs, scrotum, and penis in a

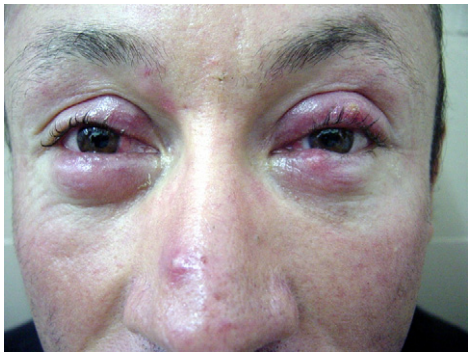

Fig 1. Erythema and edema near the eyes after 60 days of acitretin therapy.

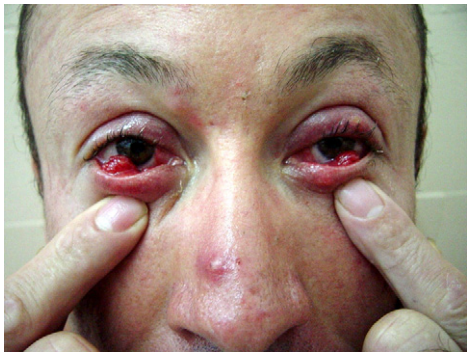

Fig 2. Excess granulation tissue on palpebral conjunctivae.

psoriatic patient receiving etretinate therapy has been reported.[4]

Granulation tissue in palbebral conjunctivae during retinoid therapy has never been described in the literature and although the temporal association between acitretin use and development of granulation tissue in our case is suggestive of etiology, a case report is not sufficient to prove it. The patient had a pustule on his nose that might suggest a diagnosis of rosacea. If the patient had rosacea, the granulation tissue could be secondary to a combination of ophthalmic rosacea complicated by the oral retinoid. However, because the patient had no other signs or symptoms of rosacea, we propose that the single pustule represented a folliculitis.

The excess granulation tissue reported with retinoids usually appears after 3 to 12 weeks of therapy,[2] but there are reports in which the reaction appeared 6 months after beginning therapy,[4] and even after the withdraw of the drug because of the long elimination half-life of etretinate.[1] In our patient, the lesions developed 12 weeks after starting the therapy, in accordance with literature on the subject.

The reaction may resolve spontaneously after the discontinuation of therapy or after reduction of the dose, suggesting that the reaction is a dose-dependent effect.[2-5] In our patient, the lesions spontaneously resolved 40 days after withdrawal of the drug.

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Simultaneous subungual melanoma in situ of both thumbs

To the Editor: Subungual melanoma represents 0.7% to 3.5% of cutaneous melanomas in Caucasians.[1,2] Although multiple melanomas can occur in one individual, two subungual melanomas in situ (MIS) occurring simultaneously on separate fingers in the same patient is rare and, to our knowledge, not previously reported.

A 38-year-old Caucasian man presented with pigmented lesions of both thumbnails. The pigmentation had been present for 5 years, was enlarging, and occurred without antecedent trauma. There was no personal or family melanoma history.

At the time of physical examination, the patient had a 1 cm—wide longitudinal blue-black band on his right thumbnail, and a similarly pigmented 3 to 4 mm—wide longitudinal band on his left thumbnail (Fig 1). There was no visible pigmentation on either proximal nailfold or hyponychium. Longitudinal nail apparatus biopsies were