Cutaneous schwannoma: an atypical presentation*

Rogerio Nabor Kondo[1] Rubens Pontello Junior[2]
Priscila da Silva Taguti[1]

DOI: http://dx.doi.org/10.1590/abd1806-4841.20176583

Dear Editor,

We report the case of a 66-year-old male patient who presented with a 10-year history of a nodular mass in the right leg region. The patient referred a gradual enlargement of the lesion, which had a quick growth in the last two years. He had arterial hypertension and hypothyroidism but no history of neurological pathologies.

Dermatological examination revealed a firm mass, slightly painful to the touch, measuring approximately 7x6cm on the right leg (Figure 1).

Ultrasound scan revealed a hyperechoic nodule without central vascularization, which suggested a lipoma with cystic degeneration.

Macroscopic examination showed a solitary smooth and well-encapsulated yellowish-white nodule with fibroelastic consistency, measuring about 6 x 5cm (Figure 2).

Microscopic examination revealed a lesion predominantly composed of fusiform cells showing both Antoni A and Antoni B areas, compatible with schwannoma (Figure 3).

The patient was submitted to tumor excision.

Schwannomas or neurilemomas are benign encapsulated tumors of nerve sheath origin. Although they commonly occur as solitary lesions (90%), they can be associated with several central neurological tumors (usually meningiomas, 5%), neurofibromatosis type 2 (3%), or appear as multiple lesions (schwannomatosis, 2%). Clinically, cutaneous schwannomas (CS) usually range in size from 0.25 cm to 3.00 cm and generally occur in the head and neck regions. Although they represent the commonest benign peripheral nerve sheath tumors (incidence rate of 5% in adults and 2% in children), the occurrence on the lower limbs account for 1% of all cases.[1-4]

Verocay first described these benign tumors derived from the myelin sheath (benign myelin sheath tumor) in 1908 as neurinomas. Later, in 1935, Stout reported on tumors arising from the nerve sheath and specifically described tumors of neuroectodermal origin. The neuroectoderm consist of Schwann cells and collagen fibers. After recognizing their schwannian derivation, Stout coined the term schwannoma.[3,4]

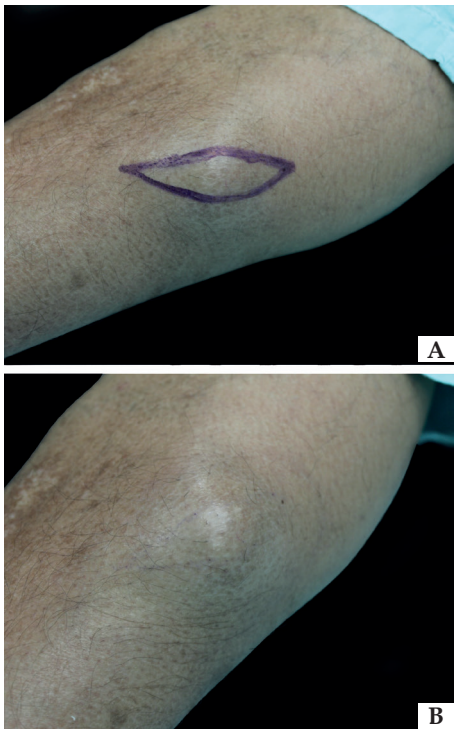

Figure 1: A. Firm mass on the right leg. **B.** Detail of the lesion

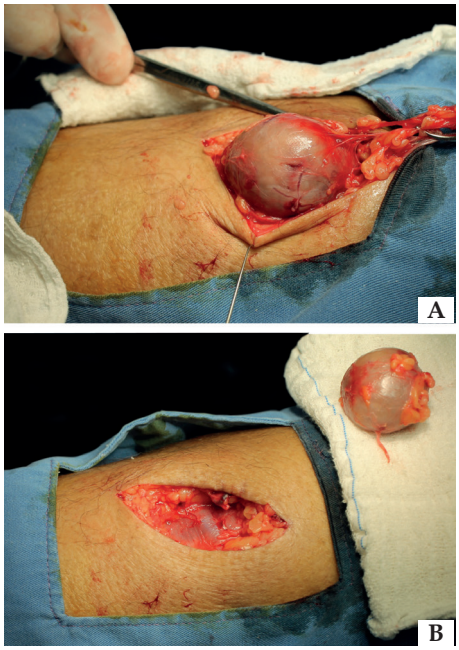

Figure 2: A. Macroscopic examination: solitary smooth and well-encapsulated yellowish-white nodule, with fibroelastic consistency (saphenous nerve region). **B.** Detail of the lesion

Received on 09.10.2016
Approved by the Advisory Board and accepted for publication on 26.12.2016
* Work performed at the Dermatology Service at Hospital Universitário Regional do Norte do Paraná da Universidade Estadual de Londrina – Paraná (PR), Brazil.
Financial support: None.
Conflict of interests: None.

[1] Hospital Universitário Regional do Norte do Paraná da Universidade Estadual de Londrina (UEL) – Paraná (PR), Brazil.
[2] Discipline of dermatology in the Medical School at Universidade Estadual de Londrina (UEL) – Paraná (PR), Brazil.

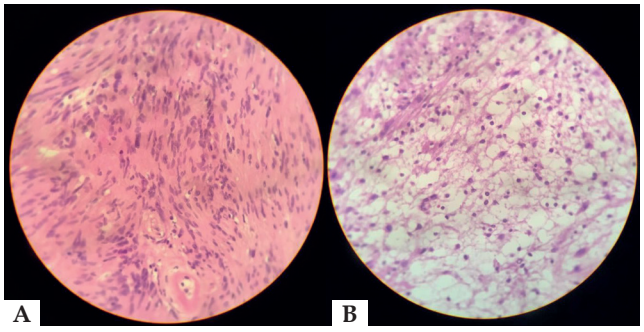

Figure 3: A. Microscopic examination: Lesion predominantly composed of fusiform cells. Antoni type A is a highly ordered cellular pattern in which spindle cells are arranged in compact fascicles and their nuclei are arranged in palisades (Hematoxylin & eosin x 400). **B.** Antoni type B tissue is less cellular with pale zones of gelatinous matrix (Hematoxylin & eosin x400)

The etiopathogenesis of CS is unknown, but they sometimes occur in people with certain disorders including some types of neurofibromatosis.[2] CS are generally asymptomatic, however, when pain is present, it is usually associated with compression the adjacent structures of nerve and the paresthesias restricted on the tumor site or radiating along nerve of origin. . CS most often occurs in the 4th and 5th decades of life, without significant evidence of sex predilection.[3] Histopathologically, CSs are typically encapsulated by perineurium and are characterized by two types of histological patterns: Antoni type A and Antoni type B. Antoni A is a highly ordered cellular pattern in which spindle cells are arranged in compact fascicles and their nuclei are arranged in palisades. Verocay bodies are a characteristic feature in Antoni type A pattern, with collagen matrix arranged into palisading.. Antoni type B tissue exhibits a looser structure of mucinous matrix and it´s less cellular.[3]

The differential diagnosis of CS includes proliferating pilomatricoma, epithelial cysts, lipoma, desmoid tumor, and rheumatoid nodule.[1-5] Although some tumors of the skin are difficult to diagnose, if they are painful, nine tumors should be considered: **l**eiomyoma, **e**ccrine spiradenoma, **n**euroma, **d**ermatofibroma, **a**ngiolipoma, **n**eurilemmoma, **e**ndometrioma, **g**lomus tumor, and **g**ranular cell tumor (LEND AN EGG).

The best treatment option is local excision.[1-4] Sonographic images may offer detailed information about the tumor location and its relationship to the vessel.[4] In our case, we detected no vascular flow or signs of central vascularization, which led to successful tumor excision.

Studies indicate that CS can be removed by delicate enucleation with an acceptable risk of injury to the nerve trunk.[3] In our case, we performed complete surgical resection of the tumor. Six months later, the patient was able to walk without assistance and without pain. He complained of discrete paresthesia.

Although this tumor may be considered common, the large size and leg location we report herein are infrequently described in the literature. More often, they are recognizable head and neck tumors that range in size from 0.25-3.00cm.[1-3] ❑

REFERENCES

1. Soares PBN, Marangon LD, Leal RM, Capistrano HM, Marigo HA. Neurilemoma: relato de caso clínico. Rer Odontol Bras Central 2012;21:458-61.
2. Martinez D, Cotrim C, Cury Chicralla P, Lupi O. Schwannoma: An unexpected presentation. Dermatol Surg. 2016;42:1112-3.
3. Nascimento G, Nomi T, Marques R, Leiria J, Silva C, Periquito J. Ancient schwannoma of superficial peroneal nerve presenting as intermittent leg pain: A case report. Int J Surg Case Rep. 2015;6C:19-22.
4. Mendeszoon MJ, Cunningham N, Crockett RS, Kushner D. Schwannoma: a case report. Foot Ankle Online J. 2009;2:4.
5. Kondo RN, Pontello Junior R, Belinetti FM, Cilião C, Vasconcellos VR, Grimaldi DM. Proliferating pilomatricoma – Case report. An Bras Dermatol. 2015;90:94-6.

Mailing address:
Rogerio Nabor Kondo
Avenida Ayrton Senna da Silva, 1055, Sala 1205
Gleba Palhano
86050-460 Londrina, PR - Brazil
E-mail: kondo.dermato@gmail.com

How to cite this article: *Kondo RN, Pontello Júnior R, Taguti PS. Schwannoma cutis: apresentação atípica. An Bras Dermatol. 2017;92(3):441-2.*

A case of unilateral blaschkoid lichen planus pigmentosus*

Mualla Polat[1] Bengü Tuman[1]
Gülzade Özyalvaçlı[2]

DOI: http://dx.doi.org/10.1590/abd1806-4841.20175664

Dear Editor,

Lichen planus pigmentosus (LPP) is a rare variant of lichen planus.[1] A few cases of LPP involving linear, blaschkoid, and zosteriform patterns have been reported in the literature.[2-4] We herein describe a case involving a 48-year-old female patient with unilateral abdominal involvement of LPP following the lines of Blaschko.

A 48-year-old female patient was admitted to our clinic with a 2-year history of a pruritic rash localized to the right half of the abdomen. The patient's medical history revealed that she had been using levetiracetam and levothyroxine for 8 years to treat epilepsy

Received on 04.02.2016
Approved by the Advisory Board and accepted for publication on 27.10.2016
* Work performed at the Abant Izzet Baysal University, Faculty of Medicine – Bolu, Turkey.
Financial support: None.
Conflict of interest: None.

[1] Faculty of Medicine, Department of Dermatology, Abant Izzet Baysal University – Bolu, Turkey
[2] Faculty of Medicine, Department of Pathology, Abant Izzet Baysal University – Bolu, Turkey