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Successful Removal of Angioleiomyoma with Ultrasonographic Evaluation

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Dear Editor:

Newer-generation ultrasonography devices are increasingly applied in the field of dermatology. Ultrasonography is less time-consuming and noninvasive. Portable ultrasonography devices enable point-of-care examination in the outpatient clinic. Minimal unwanted radiation exposure is an important reason ultrasonography is preferred.

Angioleiomyoma is a rare benign solitary tumor that originates from the vascular smooth muscle and can occur anywhere in the body, but more frequently in the lower extremities. It usually presents as a painful solitary slow-growing nodule¹.

A 33-year-old female presented with a purplish atrophic patch on her right lower leg (Fig. 1A). Three years before, she had presented to our clinic with a skin-colored firm nodule on her right lower leg, which is identical to the location of the present scar (Fig. 1B). We had performed a punch biopsy to diagnose the lesion. The histopathological

finding from the punch biopsy specimen was consistent with angioleiomyoma (Fig. 1C). As the patient did not have any discomfort after the biopsy and lesion became non-palpable, she refused further procedure. Two years later, she presented our clinic with intermittent pain on pressing the lesion. On physical examination, the patient felt mild tenderness, but no lesion was discernable under manual palpation. Further evaluation of the lesion was performed using ultrasonography (15 MHz, linear probe), which revealed a 5.7 mm × 4.7 mm sized, circumscribed homogenous hypoechoic mass in the deep subcutaneous tissue (Fig. 2A). We performed excisional biopsy of the solid mass under local anesthesia. The tumor removed appeared to be a grossly pearl-gray nodule (Fig. 2B). Its histopathological features were consistent with angioleiomyoma (Fig. 1D). We received the patient's consent form about publishing all photographic materials.

Angioleiomyoma is not commonly diagnosed preoperatively owing to its rarity and the lack of awareness among clinicians. However, high-resolution sonography has been increasingly used as the first-line modality to evaluate soft tissue tumors. Zhang et al.² investigated the clinical and sonographic features of subcutaneous angioleiomyoma. They demonstrated that the typical sonographic features of angioleiomyoma may include an oval shape, well-defined margins, a homogenous structure, and hypervascularity. By contrast, some studies reported that angioleiomyoma may show low or moderate vascular density^{3,4}.

Wortsman⁵ demonstrated sonographic features of dermatologic entities that are commonly examined with ultraso-

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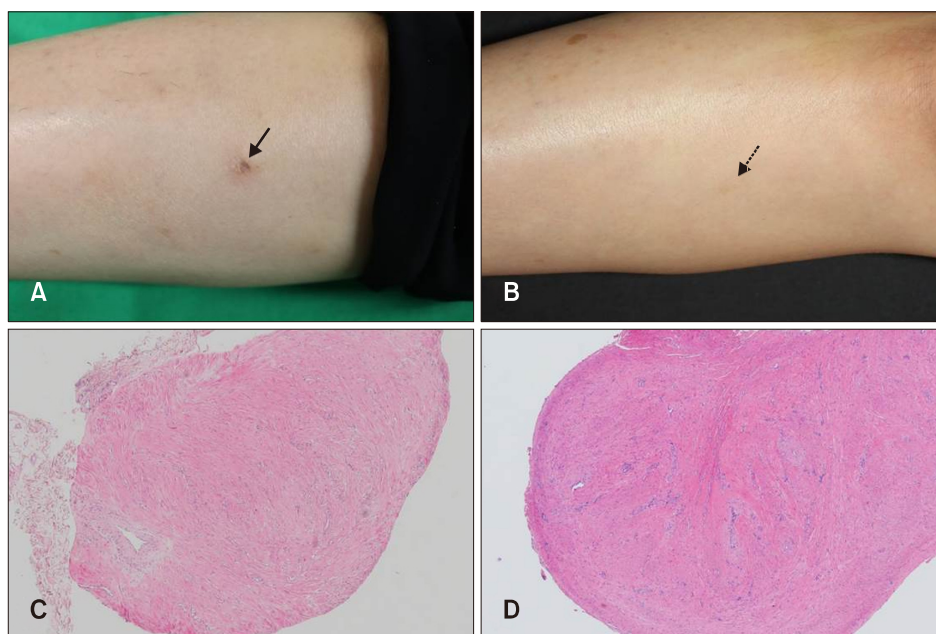


Fig. 1. (A) The purplish atrophic scar on the right lower leg (black arrow). (B) The skin-colored firm nodule detected 3 years earlier on the right lower leg, which is identical to the location of the present scar (dashed arrow). (C) Histopathological findings from previous lesion showing a well-circumscribed nodule with interlacing smooth muscle bundles and interspersed vascular lumens. The lesion was not completely removed by punch biopsy (H&E, $\times 40$). (D) Histological findings from atrophic scar like lesion showing a well-circumscribed nodule with interlacing smooth muscle bundles and interspersed vascular lumens (H&E, $\times 40$).

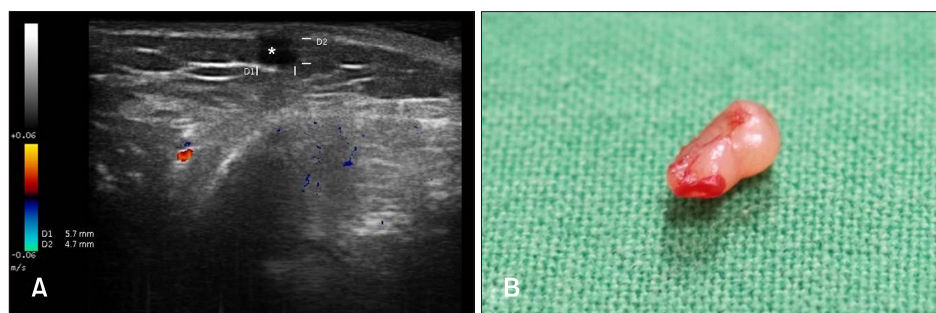


Fig. 2. (A) Ultrasonographic image of the well-circumscribed homogeneous hypoechoic mass (asterisk) in the deep subcutaneous tissue showing no hypervascularity (5.7 mm $\times$ 4.7 mm). (B) The removed mass showing a pearl-gray nodule.

nography. The author described not only mass lesions but also inflammatory/infectious dermatoses, ungual lesions, and exogenous materials.

Dermatologists can correlate objective information from ultrasonography with clinical findings to guide their diagnostic and therapeutic decisions. In our case, although the lesion was disguised as an atrophic scar, correlating its clinical features such as lesion location, previous history, and ultrasonographic examination findings enabled us to overcome the diagnostic difficulty and make a correct diagnostic decision. By using ultrasonography, dermatologists can evaluate the real-time and long-term efficacy of treatment. In our case, the hypoechoic mass on ultrasonography indicated that the treatment performed 3 years prior was inadequate.

By reviewing our case and the dermatologic use of ultrasonography, we emphasize the importance of ultrasonography in the field of dermatology and dermatologists' knowledge of and proficiency at performing ultrasonography.

CONFLICTS OF INTEREST

The authors have nothing to disclose.

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A Case Report of Pathergy-Like Reaction in a Patient with Behçet's Disease Triggered by Wax Epilation

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Dear Editor:

The diagnosis of Behçet's disease is based on clinical findings and pathergy test positivity supports the diagnosis¹. Pathergy reaction, first described by Blobner in 1937, is a nonspecific inflammatory response of the skin to trauma. Pathergy test is usually performed on the flexor forearm by at least two intradermal punctures with a 20~22 gauge needle, and the test is considered positive if an erythematous papule or pustule is seen at the puncture site af-

ter 24~48 hours. Although it is considered as hyper-reactivity of the skin to intradermal prick, papulopustular lesions after laser epilation and oral aphthous lesions developing right after orthodontic treatment were also regarded as a manifestation of pathergy reaction². Here we present a patient with diffuse papulopustular lesions after wax epilation, a pathergy-like reaction which has not been reported previously in the literature.

A 31-year-old, patient with BD admitted to our department with papulopustular lesions that had developed on the pubic area in two days following wax epilation. The patient was diagnosed as BD due to recurrent oral ulcers, genital ulcers, erythema nodosum lesions, and a positive pathergy test. One year ago, the patient had had deep vein thrombosis of the lower extremity but had no other evidence of systemic involvement. Dermatologic examination revealed a minor aphthous ulceration on the oral mucosa, erythema nodosum lesions on lower extremities and papules and pustules localized only in the genital area. Routine hematologic and biochemical tests were normal, the sedimentation rate was 20 mm/hour and C-reactive

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