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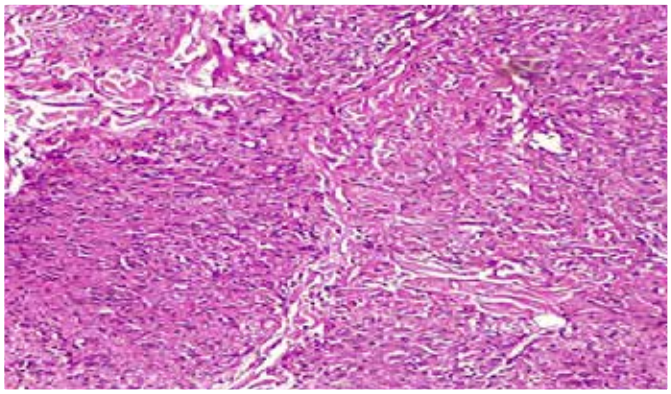
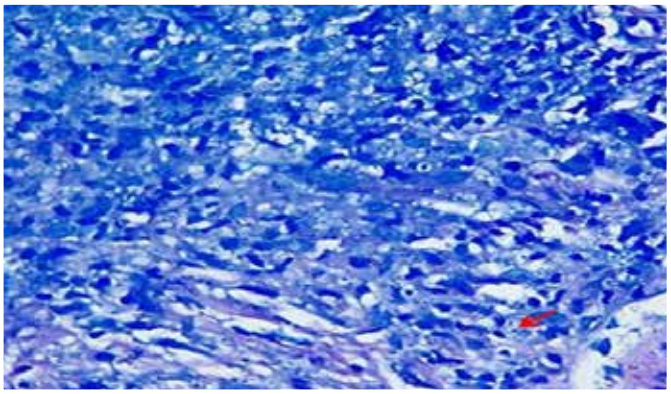
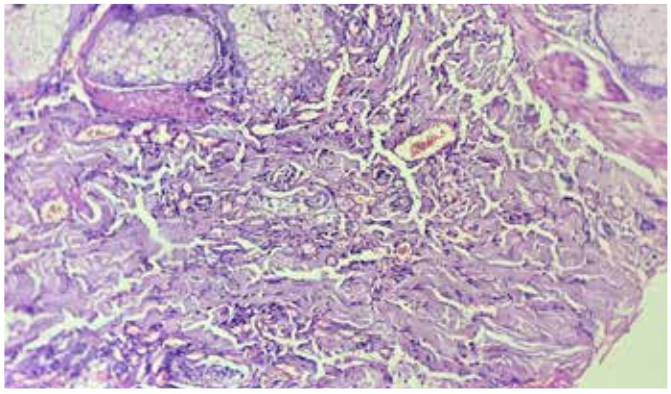
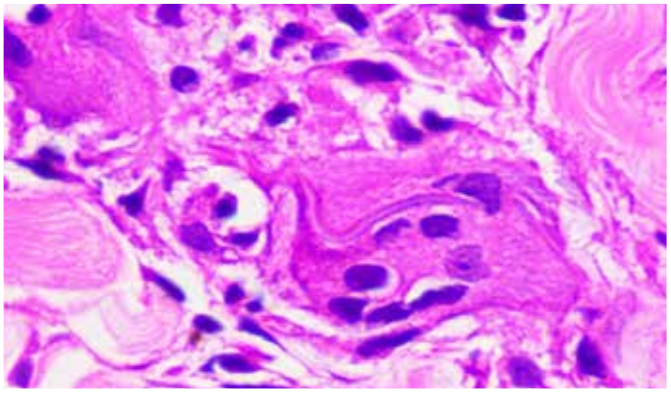
SIG DERMATOPATHOLOGY

NEWSLETTER- 2022









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PREFACE

DR MEGHANA PHISKE
(SIG Coordinator)

DR GEETI KHULLAR
(SIG Convener)

DR SANJANA AGRAHARA
(SIG Member)

DR SUBHRA DHAR
(SIG Member)

Dear All,

Greetings from the editorial team of SIG Dermatopathology Newsletter. We have finally shaken off the pandemic induced lethargy and are happy to bring to you an interesting content that will intrigue and stimulate our readers. For those who have missed out on reading journals, there is a compilation of interesting abstracts highlighting the most important articles. For the young PGs we have basic aspects of dermatopathology as well as a challenging quiz. We have tried to address some conundrums too which will provide clarity in our practice. Clinicopathological correlation which forms the backbone of any dermatology case has been used to solve some interesting cases. And last but not the least we are carrying some snippets of past activities of SIG Dermatopathology and also throwing light on the way forward. A lot of hardwork has gone into making this newsletter engaging and interesting. Hope you all will enjoy it!

Happy reading!

Section 1

Brief compilation of interesting abstracts from recent publications

Authors

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Abstract 1

A Case of Tofacitinib-Induced Lymphomatoid Papulosis With Ocular Involvement

Knapp C 3rd, Steele E, Mengden-Koon S, Williams T, Fett N. A Case of Tofacitinib-Induced Lymphomatoid Papulosis With Ocular Involvement. Am J Dermatopathol. 2022 Jul 1;44(7):523-525

Janus kinase (JAK) inhibitors are being prescribed with increasing regularity in dermatology. A patient who initiated treatment with tofacitinib for refractory erythema elevatum diutinum subsequently developed a novel cutaneous outbreak characterized by firm violaceous papules on the trunk and extremities along with conjunctival injection and periorbital inflammation. Biopsy of affected tissue from both the cutaneous and ophthalmologic sources demonstrated

increased numbers of CD30+ large atypical cells amid a mixed inflammatory cell infiltrate, consistent with lymphomatoid papulosis. A plausible mechanism proposed by the authors is, persistent JAK signalling in the presence of a JAK inhibitor. Continued vigilance with the use of these immunologic agents is recommended.

Abstract 2

Mycobacterium leprae Immunostaining Pitfall

Kaur H, Goode WT, Scott G. Mycobacterium leprae Immunostaining Pitfall. Am J Dermatopathol. 2022 Jun 1;44(6):465-466.

IHC has become increasingly popular to detect T. pallidum because it is more sensitive than traditional silver stains. The authors report an example of artefactual staining of lepra bacilli from a patient's skin biopsy with antibodies against Treponema pallidum.

Case: A 64-year-old South Asian woman presented to clinic with multiple enlarging, well-circumscribed erythematous plaques on her chest. Biopsy from a representative lesion showed dermal superficial and deep nonnecrotizing granulomas with epithelioid macrophages, plasma cells, and lymphocytes around blood vessels and dermal appendages. An IHC stain against T. pallidum highlighted abundant positively staining organism with a rod-shaped morphology. However, FITE acid-fast stain revealed abundant bacilli inside macrophages in the dermis forming clusters (globi) and extracellularly. M.leprae was confirmed by PCR testing.

The authors caution that a positive T. pallidum IHC stain should be supported by a negative Fite-Faraco/AFB stain, to prevent an erroneous diagnosis of syphilis.

Abstract 3

The presence of mast cells in lichen planopilaris and discoid lupus erythematosus of the scalp: A quantitative study.

Shahidi-Dadras, M, AsadiKani, Z, Dadkhahfar, S, Zartab, H, Rakhshan, A. The

presence of mast cells in lichen planopilaris and discoid lupus erythematosus of the scalp: A quantitative study.J CutanPathol. 2022; 49(5): 448- 453.

A total of 74 cases comprising 50 cases of LPP and 24 cases of DLE were assessed. The mean mast cell count per HPF was 42.64 ± 16.81 (ranged 3-99) in the LPP group and 15.54 (±10.78) in the DLE group ($p < 0.001$). Mean percentage of mast cells in the infiltration was 27.41% in LPP patients compared with 12.19% in DLE group ($p < 0.001$). Most of the specimens, 58 (78.4%), showed both perifollicular and perivascular distribution of mast cells without significant difference between two groups. No association was found between mast cell numbers and amount of dermal fibrosis, in either groups. The authors suggest that mast cell count detected by Giemsa staining could assist pathologists in distinguishing between LPP and DLE.

Abstract 4

Spongiotic Pattern in Pemphigus: A Retrospective Observational Single-Center Study.

Preclaro IAC, Wu Y-H. Spongiotic Pattern in Pemphigus: A Retrospective Observational Single-Center Study.Dermatopathology. 2022; 9(2):172-182.

Acantholysis may be absent, and pemphigus may present only with spongiosis and vesiculation, thereby leading to a misdiagnosis of eczema.The authors analysed 99 immunopathologically diagnosed pemphigus specimens. Cases of spongiotic dermatitis were used as control. In 41/99 samples of pemphigus, spongiosis was identified.Spongiosis in the middle to lower thirds of the perilesional epidermis ($p = 0.030$), exocytosis with either neutrophils or eosinophils ($p = 0.016$), dermal infiltrates composed of lymphocytes, eosinophils, and neutrophils ($p = 0.012$), and absence of Langerhans cell microabscesses ($p < 0.001$) were more common in pemphigus than control., while about one quarter of the pemphigus specimens did not have acantholysis. Further, acantholysis in the spongiotic area may not always indicate pemphigus as acantholysis was also frequently seen in the control group (55%, $p = 0.358$).However, these

acantholytic cells were all floating in the microvesicles, adjacent to inflammatory cells. The pattern was different from diffuse acantholysis in pemphigus.Although the intensity of inflammation between the two groups was not significant, the intensity of dermal inflammation in the control group coincided with vesicle formation, in contrast to the pemphigus group, where vesicle formation occurred despite the intensity of dermal inflammation.The authors suggest that the presence of spongiosis predominantly infiltrated with neutrophils or eosinophils in the lower to middle thirds of the epidermis, as well as the absence of Langerhans cell microabscesses, may provide subtle clues in cases of pemphigus without prominent acantholysis.

Abstract 5

Perspectives in Dermatopathology

Digital dermatopathology: The time is now

Blum AE, Murphy GF, Lee JJ,Journal of Cutaneous Pathology.2021 Apr;48(4):469-471.

To continue to provide expert specialized care during the COVID-19 pandemic, our dermatopathology service transitioned to a secure virtual microscopy platform. In our experience, this digitally-enabled dermatopathology practice revealed myriad benefits, including an improved diagnostic workflow and increased access to teaching. Whole slide imaging (WSI) is a related system that digitizes glass slides with high resolution and has been clinically validated for primary diagnosis. While WSI requires an initial institutional investment, its benefits include expanded access to subspecialized expertise and collaborations, digital histopathologic data generation for research, unification of patient clinical and pathologic information, and archiving of educational resources. The switch to digitally-enabled remote dermatopathology at our institution and across the United States presents a rare opportunity to critically examine newly implemented systems and to develop permanent digital solutions, thereby taking a leap forward for the benefit of patient care, research, and medical education.

Abstract 6

Histopathological and Clinical Analysis of Skin Rashes in Children With Multisystem Inflammatory Syndrome Associated With COVID-19

Yuksel S,Demirkan NC,Comut E, Yilmaz M,Gurses D, The American Journal of Dermatopathology: March 2022 - Volume 44 - Issue 3 - p 183-189

Introduction: A new entity, which occurs a few weeks after SARS-CoV-2 infection and resembling incomplete Kawasaki disease or toxic shock syndrome, has been defined and named multisystem inflammatory syndrome (MIS-C) associated with COVID-19 in children. The aim of our study was to describe histopathological characteristics of skin lesions of MIS-C patients to reveal whether there is a relationship between histopathological features and clinical manifestations.

Materials and methods: Seventeen who had skin involvement of 57 patients who were diagnosed with MIS-C between December 2020 and February 2021 were included in this prospective study. Demographic information, laboratory findings, and patients' managements were recorded. Skin biopsies were taken simultaneously of each patient. Formalin-fixed, paraffin-embedded skin samples were examined microscopically.

Results: The rate of skin rash was 30% in patients with MIS-C and was predominantly the maculopapular type. The anatomical distribution of the rash was evaluated as localized in 10 and generalized in 7 patients. In patients with myocarditis, C-reactive protein and fibrinogen were found to be significantly higher, and lymphocyte and albumin values were found to be low. Herpes-like inclusions were found in the microscopic examination of 2 patients with a history of zona zoster in themselves or in their mother. There was a significant difference between keratinocyte necrosis and some clinical parameters.

Discussion: Localized skin lesions appear to be associated with a more severe inflammation.

Abstract 7

Cutaneous solitary fibrous tumor: Report of three cases with review of histopathological mimics

Vincek V, Kallis P, Vause A, Vincek E, Ilkovitch D, Motaparthi K. J CutanPathol. 2022 Feb;49(2):167-171.

Solitary fibrous tumor (SFT) is a relatively uncommon spindle cell mesenchymal neoplasm that is most often based on the pleura but may rarely arise in extrapleural locations, including the skin. Herein, we describe three cases of cutaneous SFTs. SFT is characterized by epithelioid and spindle cells arranged in random patterns with focal prominent stromal collagen and pericytomatous vessels. Immunohistochemical evaluation is required for definitive distinction of SFT from other benign and malignant cutaneous spindle cell neoplasms. Although aggressive biologic behavior is uncommon, accurate diagnosis of it is required for prognostication and counseling. CD34, bcl-2, and CD99 stains are positive in SFT, but not specific. STAT6 is the most sensitive and specific immunohistochemical marker to confirm diagnosis of SFT.

Abstract 8

Pseudoepitheliomatous keratotic and micaceous balanitis: A distinct entity.

Salloum A, Bachour J, Bazzi N, Megarbane HA. Indian Journal of Dermatopathology and DiagnosticDermatolology2021;8:20-2

Pseudoepitheliomatous keratotic and micaceous balanitis (PKMB), an uncommon glans penis skin disorder, affects mainly elderly men and can progress to verrucous carcinoma or invasive squamous cell carcinoma. A 22-year-old male presented with a 5-year history of a slightly pruritic thick scaly plaque on the glans penis that appeared 2 months after undergoing circumcision. Physical examination revealed a well-defined hyperkeratotic plaque with thin mica-like scales. Histological examination of previous biopsies showed acanthosis with elongation of the rete ridges, prominent granular cell

layer, and marked orthokeratotic hyperkeratosis. The diagnosis of plaque-stage PKMB was made. The patient had monthly sessions of topical liquid nitrogen and after 20 weeks, the plaque shrank significantly.

Section 2

Interesting clinico-pathologic cases

Case 1

Elderly male with a violaceous plaque and satellite lesions involving face: a case report

Author: Dr Jignaben K Padhiyar, Assistant Professor, Dept of DVL, GCSMCH&RC, Ahmedabad.

Case history:

A 75-year-old male patient presented with violaceous to reddish skin lesions over face for last one and half year. The patient had a single, well demarcated, non-tender, heterogenous violaceous plaque involving face with few skip areas (Figure 1). There were few satellite lesions on right side of the face (Figure 2).A single violaceous nodule was present over nose. Patient had been treated with many supplements in past, but lesions did not improve. Differential diagnosis of Kaposi sarcoma, Kaposi-like hemangio-endothelioma, angiolymphoid hyperplasia and cutaneous angiosarcoma were considered. All routine investigations (complete blood count, liver, and renal function tests) chest Xray and USG abdomen were normal. USG local part showed presence of diffuse ill-defined complex echogenic lesion with internal vascularity which was noted in the subcutaneous plane of bilateral cheeks, infraorbital region and nose showing arterial vascularity with presence of feeding vessels. This was suggestive of a vascular malignant mass. PET-CT scan was done which showed hypermetabolic heterogeneously enhancing soft tissue density lesions involving the cutaneous and subcutaneous plane of bilateral cheeks consistent with neoplastic aetiology and few hypermetabolic enlarged lymph nodes in the submental region appearing suspicious for metastases.

Clinical image :

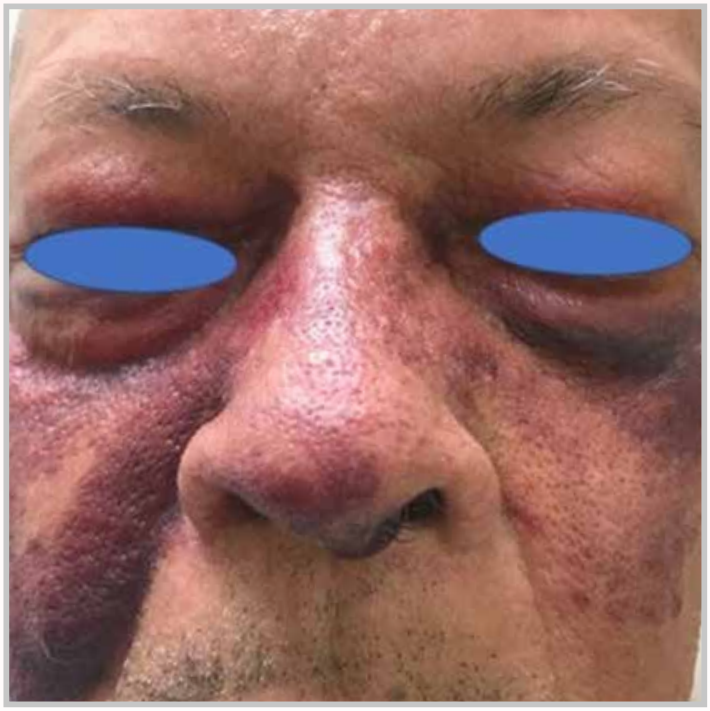

Figure 1: Violaceous to erythematous plaque on face with a nodule on nose

Figure 2: Skip areas and satellite lesions on right cheek

Histopathological finding:

Skin biopsy showed numerous anastomosing vascular channels (Figure 3) and ramifying vessels dissecting through collagen bundles in dermis (Figure 4) pleomorphic and mitotically active endothelium, endothelial cells forming solid nests within vascular lumina (Figure 5).On further investigations, immunohistochemistry of the skin biopsy revealed that the tumour cells were positive for CD34, CD31 and VEGFR with Ki proliferation index of 6-8% favouring the diagnosis of angiosarcoma.

Histopathological images:

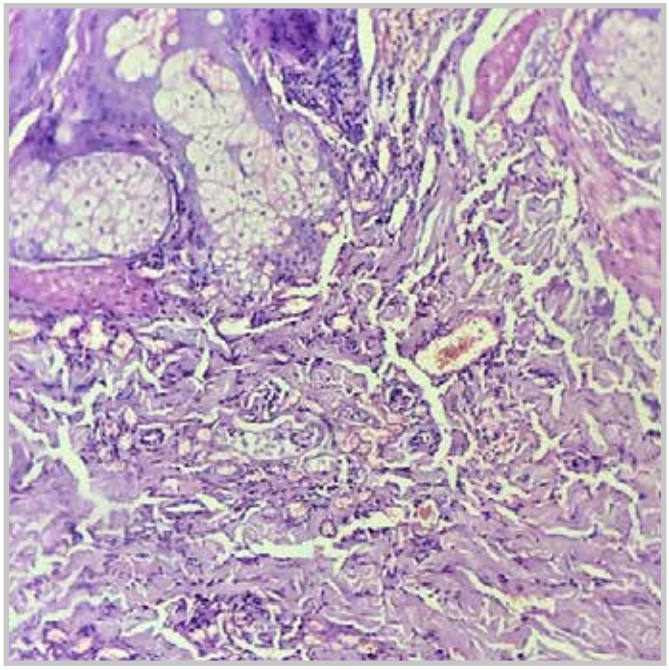

Figure 3: H&E,40x, numerous anastomosing vascular channels

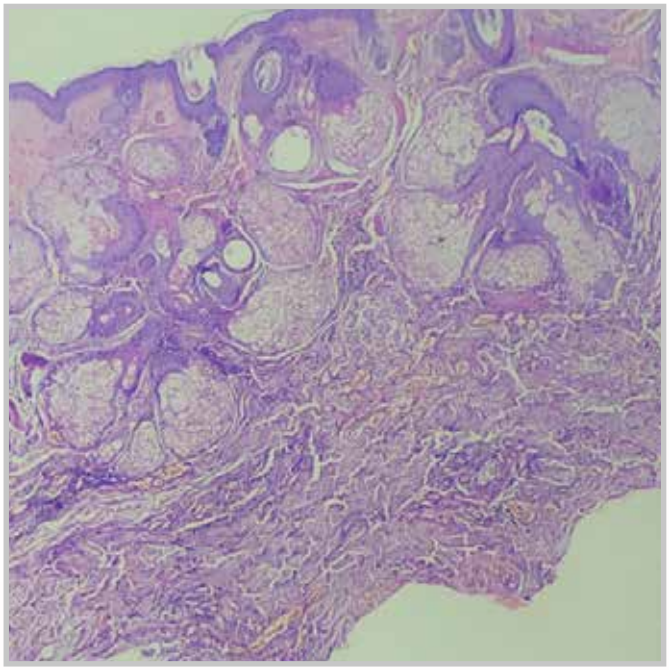

Figure 4: H&E,100x irregular branching vessels dissecting collagen bundles

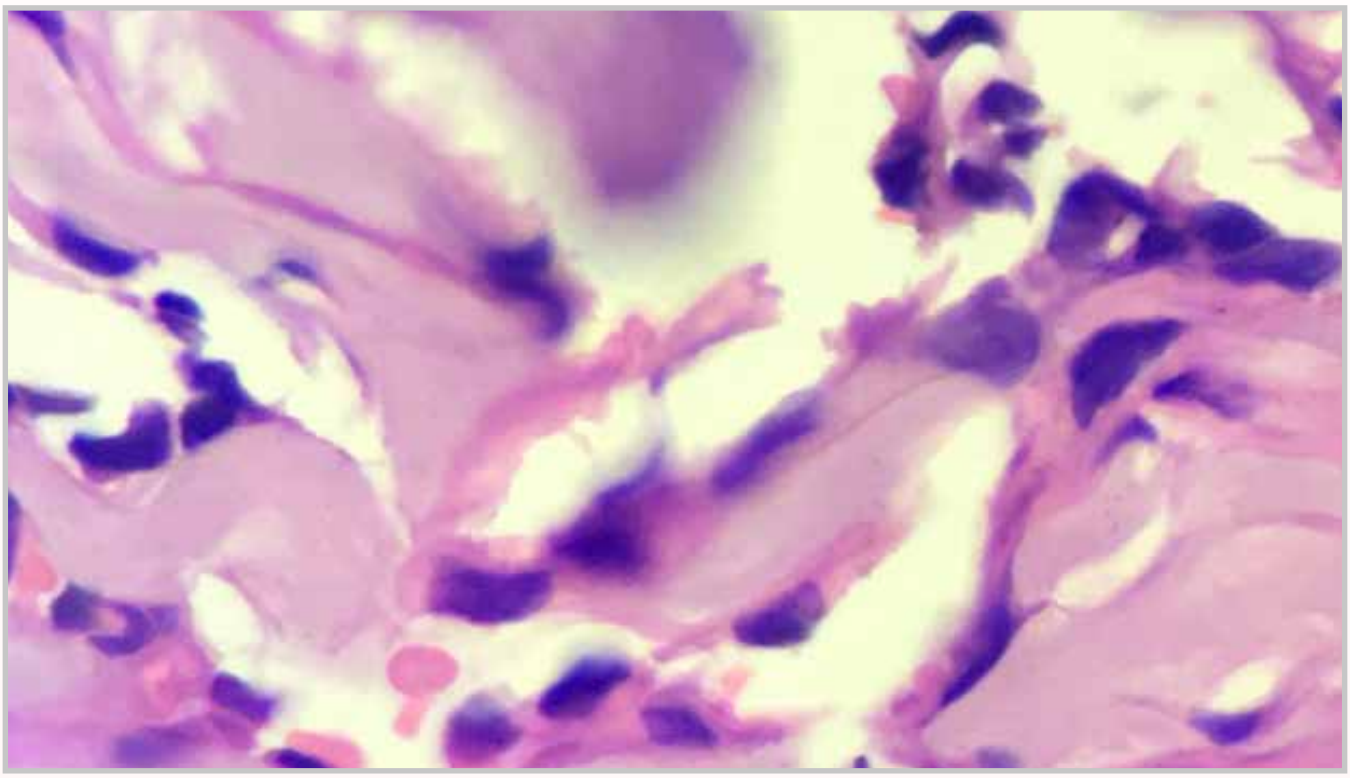

Figure 5: H&E,400x solid nests of endothelial cells within vascular lumina

Discussion :

Cutaneous angiosarcoma, a soft tissue sarcoma, represents 2% of all soft tissue sarcomas (1). It more commonly occurs in males (male to female ratio being 3:1). Cutaneous angiosarcoma can be primary or secondary due to radiation or can be associated with chronic lymphedema. Rapidly expanding erythematous to violaceous patch is the most common clinical presentation (2).

Poor prognostic factors for cutaneous angiosarcoma include diameter >5 cm size, metastasis, > 3 mm of depth of invasion on histology, high mitotic rate, positive surgical margins, and/or tumour recurrence (3). Our case had larger diameter, metastasis, and more than three mm depth of invasion on histology.

An early diagnosis in such cases is essential due its nature of rapid progression and tendency to metastasis. Modes of treatment include surgical excision, radiotherapy, medical therapy (paclitaxel, pazopanib, propranolol etc) and immunotherapy(1). In our patient, final diagnosis of cutaneous angiosarcoma with lymph node metastasis was made and the patient was referred to cancer institute for radiotherapy.

A delay in its diagnosis can make treatment and complete surgical excision very difficult and sometimes inoperable in late cases. Therefore, a high index of suspicion should be kept in a long-standing vascular lesion especially in elderly patients.

Declaration: Author declares that they have taken consent for publishing photograph of patient.

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2021;14(6):22-24.

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Case 2

A curious case of diffusely infiltrated skin with disseminated nodules over face, trunk, lower extremities and ulcerations over legs

Author: Dr Subhra Dhar (MD), Consultant Dermatopathologist & Head, Wizderm Pathlab, Kolkata, India

Clinical history:

A 38-year-old male presented with asymptomatic raised lesions on face since 3 years and raised lesions on lower extremities with large raw areas since 14 months. Cutaneous examination revealed infiltrated face with discrete skin colored papules and nodules on alae nasai, left lower lip, chin and forehead (Figure 1).Both lower limbs showed diffuse infiltration and hyperpigmentation with overlying skin colored nodules and large irregular 10x5 cm ulcer, over dorsal aspect of foot with surrounding edema. (Figure 2). There was no significant thickening of peripheral nerves and/or glove and stocking anaesthesia. HIV ab testing on 2 consecutive occasions was negative.Clinical diagnosis was lepromatous leprosy and the punch biopsy came with a request for Fite Faraco stain.

Clinical images:

Figure 1: Infiltrated face with discrete skin colored nodules on alae nasai, left lower lip, chin and forehead

Figure 2: Diffuse infiltration and hyperpigmentation over bilateral lower limbs with overlying skin colored nodules. Large irregular ulcer, 10x5 cm over dorsal aspect of foot with surrounding edema

Histopathological examination :

The epidermis showed irregular acanthosis. The upper dermis was relatively free. The mid to lower dermis was packed with somewhat oblong granulomas composed of epitheloid cells, histiocytes, and lymphocytes admixed with few polymorphs and plasma cells (Figure 3). On high power examination, the cytoplasm of histiocytes and epitheloid cells showed presence of round basophilic bodies which stained positively with Giemsa stain (Figure 4).

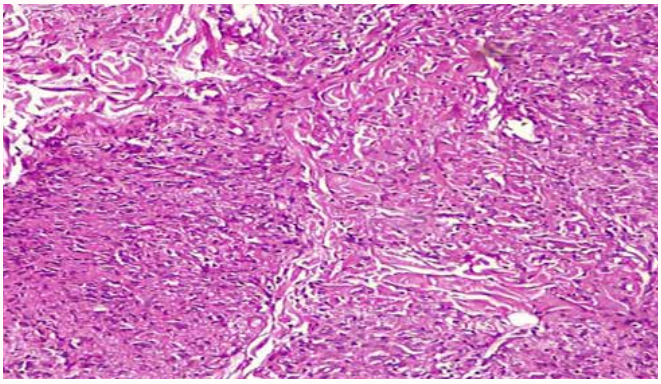

Figure 3: H&E 100 x: Several packed oblong granulomas in the dermis

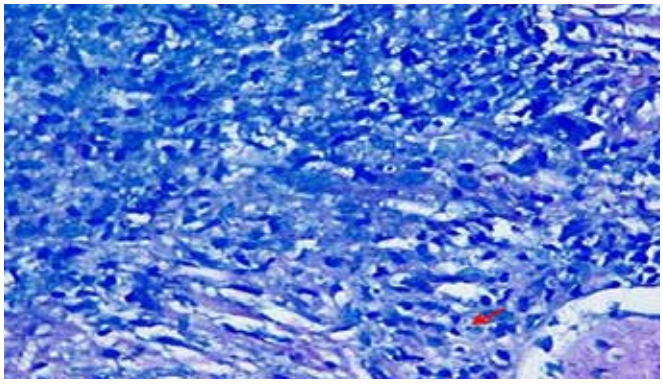

Figure 4: Giemsa stain showed positively stained leishmania bodies within cytoplasm of histiocytes and epitheloid cells

Diagnosis:

Based on the clinical history, clinical examination and histopathological examination a diagnosis of diffuse cutaneous leishmaniasis with ulceration was made.

Learning points:

- Leishmaniasis is a vector borne disease caused by protozoan flagellates and transmitted by phlebotomine sand flies
- Three main forms: VL, CL and ML
- Another cutaneous form -PKDL occurs in pts of treated/partially treated visceral leishmaniasis

- Important to keep the possibility in mind because of close resemblance to lepromatous leprosy
- Histologically, LD body should be differentiated from Histoplasmosis by employing special stains

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Case 3

Folliculotropic Mycosis Fungoides

Author: Dr Nandakumar G, Professor of Pathology, Government Medical College, Trivandrum, Kerala

Case history:

Seventy-year-old male presented with raised lesions over the head and neck area of several years duration. The lesions were asymptomatic and slowly progressing and hence the patient delayed taking medical help. Recently they were becoming more reddish, pruritic with associated pain. There was no history suggestive of any comorbidities.

Dermatological examination revealed presence of multiple, erythematous, papulonodular lesions almost confined to head and neck region (Figure 1). The lesions had apparently started as asymptomatic small papules. There was bilateral cervical lymphadenopathy, no peripheral nerve thickening and no hepatosplenomegaly.

Figure 1 : Multiple, erythematous, papulonodular lesions almost confined to head and neck region

A deep skin biopsy was done from one of the nodules.

Histopathology showed an atrophic epidermis. Mid and lower dermis showed nodular aggregates of mononuclear cells, many with high N:C ratio, pleomorphic vesicular/hyperchromatic irregular nucleus. An admixture of mature lymphocytes and few plasma cells were noted. The nodular infiltrate showed a tendency for localization around pilosebaceous structures

(Figure 2, 3, 4).

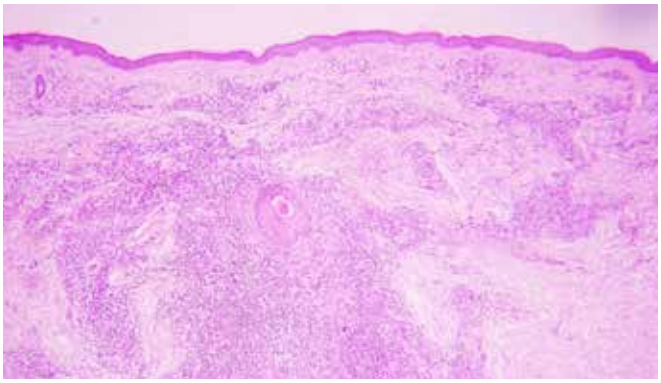

Figure 2: H&E 4x: Atrophic epidermis. Mid and lower dermis showed nodular aggregates of mononuclear cells

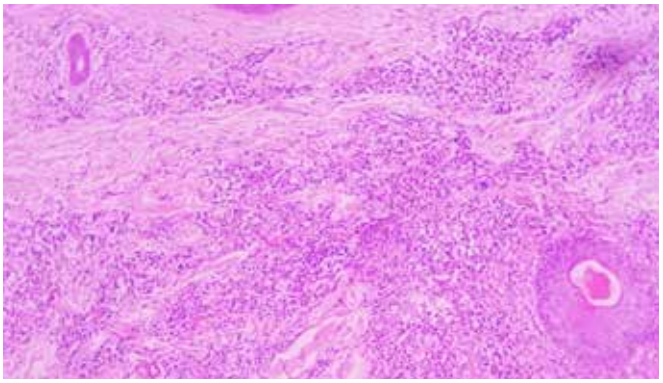

Figure 3: H&E 10x: Nodular infiltrate localized around pilosebaceous structures

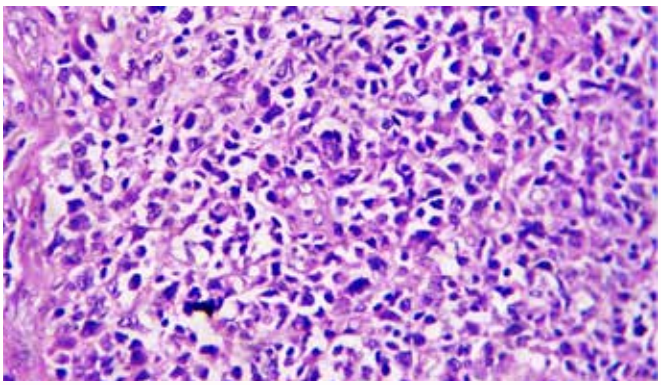

Figure 4: H&E 40x: Aggregates of mononuclear cells, many with high N:C ratio, pleomorphic vesicular/hyperchromatic irregular nucleus.

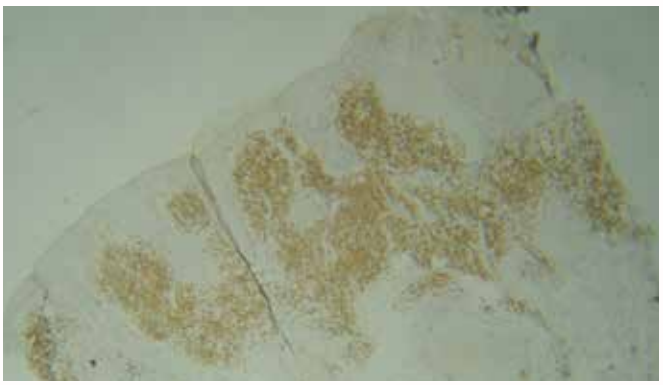

Figure 5: IHC: Atypical cells positive for CD4

With a possible diagnosis of lymphoproliferative disease, IHC work up was done. Atypical cells were positive for CD3, CD4 (Figure 5) and negative for CD20, and CD8. Few cells were CD30 positive. Ki 67 showed a high proliferative index of more than 40%.

CBC showed mild neutrophilia, peripheral blood picture was negative for atypical cells. FNAC of cervical lymph node showed reactive hyperplasia. Based on clinicopathological findings and IHC correlation a diagnosis Folliculotropic mycosis fungoides was made.

Discussion:

Folliculotropic mycosis fungoides is seen more commonly in males, tends to be pruritic, affects head and neck region and is associated with poorer prognosis.

The disease has a tendency to affect nails. The lesions are acneform or comedonal to begin with later progressing to nodule and even cystic lesions. Pilosebaceous units may become dilated.

The diagnosis tends to be missed in the early stages and may be confused with other folliculo centric diseases like Lichen planus or Lupus erythematosus. Histopathology differs from classical mycosis fungoides by the absence of epidermotropism. The deep location of infiltrate may be one reason for poor response to skin directed therapies. Clinical awareness and the point that all bottom heavy infiltrates are not B cell phenotype help one in identifying this condition.

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Case 4

Annular elastolytic giant cell granuloma of O'Brien

Authors: 1. Dr.Kinjal Rambhia, Associate Professor, Department of Dermatology, HBT Medical College and Dr. RN Cooper Hospital, Mumbai

2. Dr.Sweta Rambhia, Consultant Dermatologist, Just Care Skin and Dental Clinic.

3. Dr. Amit Gulati Consultant Dermatologist, AKIRA Skin and Hair Clinic, Mumbai.

Case history:

A 50 year old female presented with multiple asymptomatic skin coloured papules on the trunk and extremities since 1 year.

Clinical findings:

Clinical examination revealed multiple well defined, discrete, erythematous, waxy papules and plaques on the hands and trunk. Few plaques showed an annular morphology. Most of the lesions were seen on the photoexposed areas of the upper extremities and trunk (Figure 1,2)

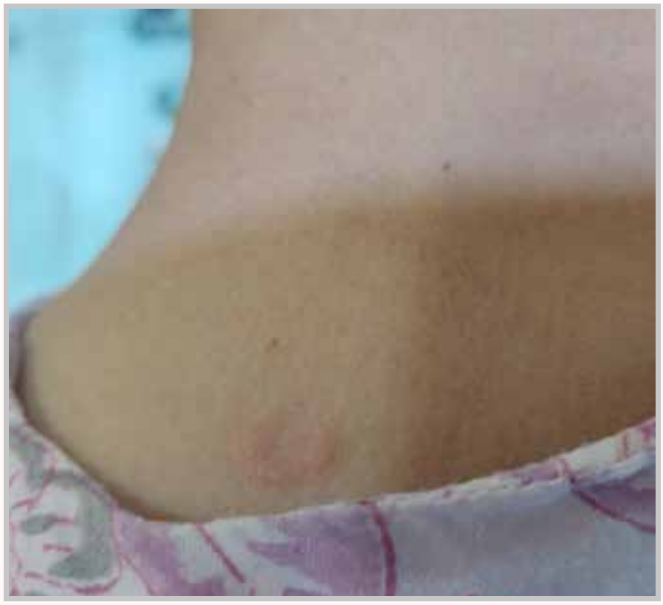

Figure 1: Annular erythematous plaque on the back

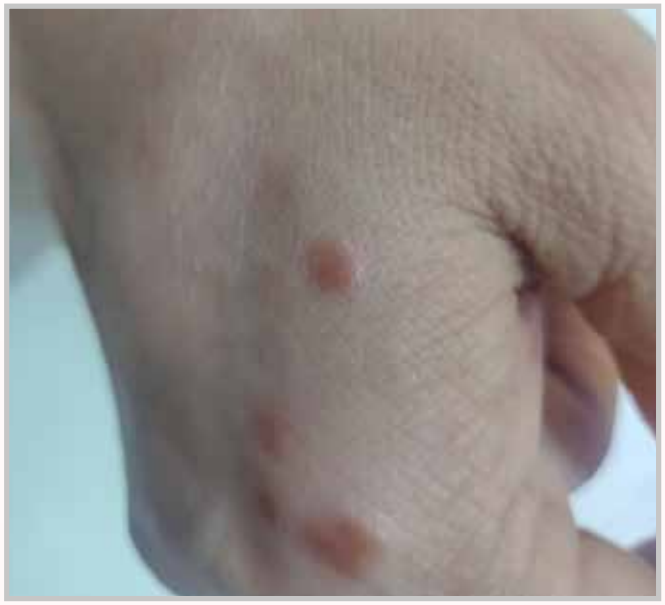

Figure 2: Erythematous papules on the hand

Clinical Differential Diagnoses :

1. Granuloma Annulare 2. Hansen's disease 3. Sarcoidosis 4. Xanthogranuloma

Histopathological findings:

Histopathology of the waxy annular plaque showed moderately dense superficial and deep perivascular lymphocytic infiltrate with numerous histiocytes and multinucleated giant cells seen scattered in the intersititum of reticular dermis. The overlying epidermis was unaffected. In focal areas elastophagocytosis was seen (Figure 3, 4, 5).

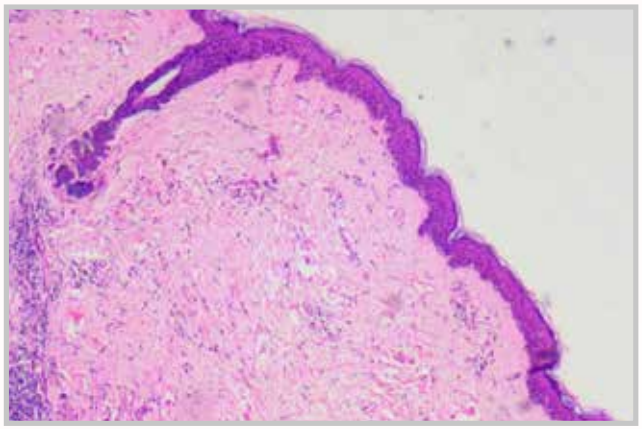

Figure 3: H&E, 4X superficial and deep perivascular and interstitial infiltrate of lymphocytes and histiocytes in the dermis

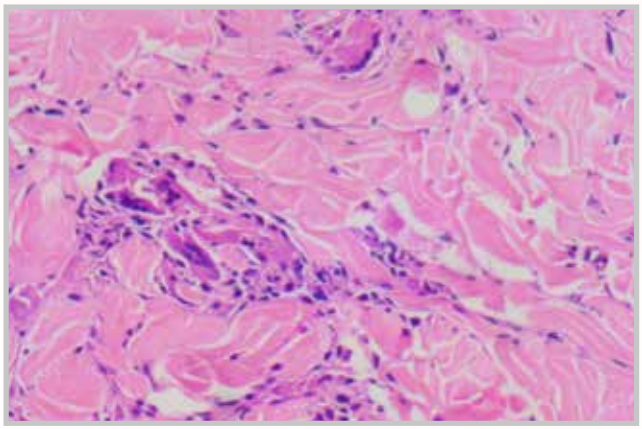

Figure 4: H&E,10X multiple histiocytes, giant cells and lymphocytes in the interstitial dermis.

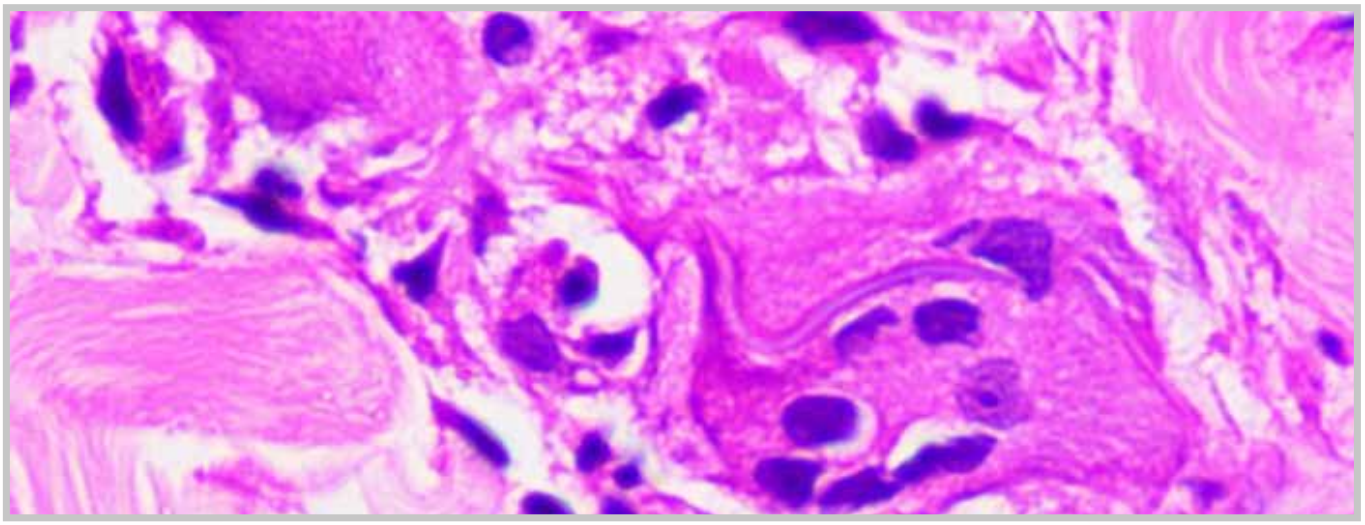

Figure 5: H&E, 40X Giant cell with elastophagocytosis.

Discussion:

Annular elastolytic giant cell granuloma of O'Brien is a rare idiopathic chronic inflammatory disorder known to occur in middle aged adults.[1] It is characterized by annular plaques mainly found on photo-exposed skin. The pathogenesis of this condition has not been clearly understood and is debatable. It is clinically characterised by reddish brown to tan coloured plaques over the sun exposed areas. Histopathological variants include Giant cell variant, Necrobiotic variant, Sarcoid variant and Histiocytic variant. [2,3]

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3. Mistry AM, Patel R, Mistry M, Menon V. Annular Elastolytic Giant Cell Granuloma. Cureus. 2020 Nov 12;12(11):e11456.

Section 3

Dermatopathology Quiz: Some Brain Teasers

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Case 1

A 16-year female presented with multiple reddish-brown flat-topped papules and plaques. The histology of the skin biopsy is shown here (Figure 1). What is the most common skin malignancy that can occur as a complication of this?

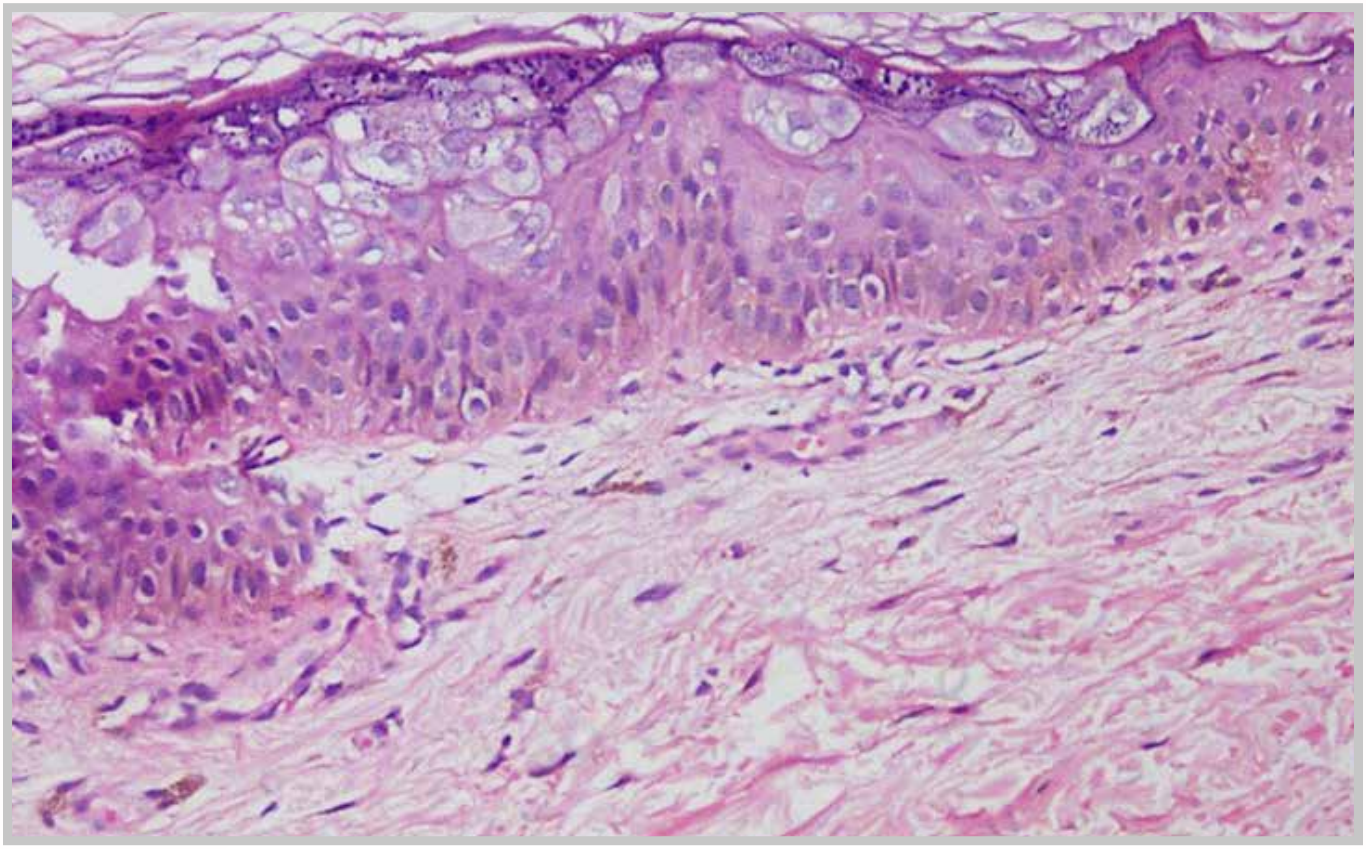

Figure 1

Case 2

A 67-year female presented with a single reddish nodule over her face. The histology of the nodule is shown here (Figure 2). The tumor cells are positive for pan-cytokeratin, keratin 7, GATA3, GCDFP, and negative for keratin 20, p40, melan A, vimentin, CD45, and show loss of e-cadherin. What is the most probable diagnosis? What investigation should be done next?

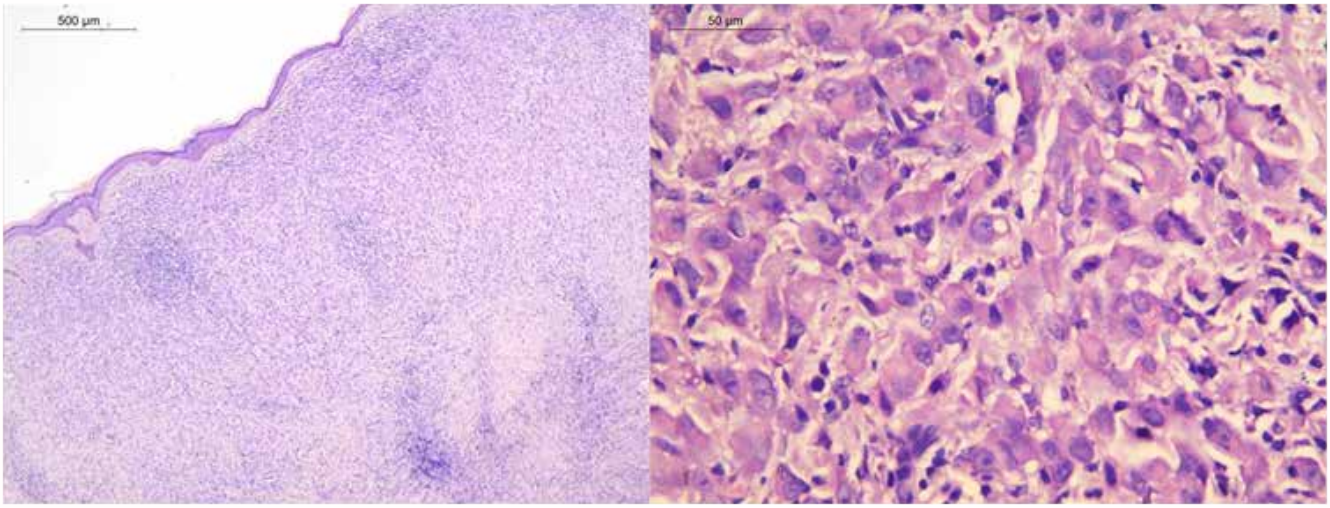

Figure 2

Case 3

A 6-year boy presented with a solitary papule on his buttock measuring 6 mm. The histology of the excised lesion is shown here (Figure 3). Spot the diagnosis.

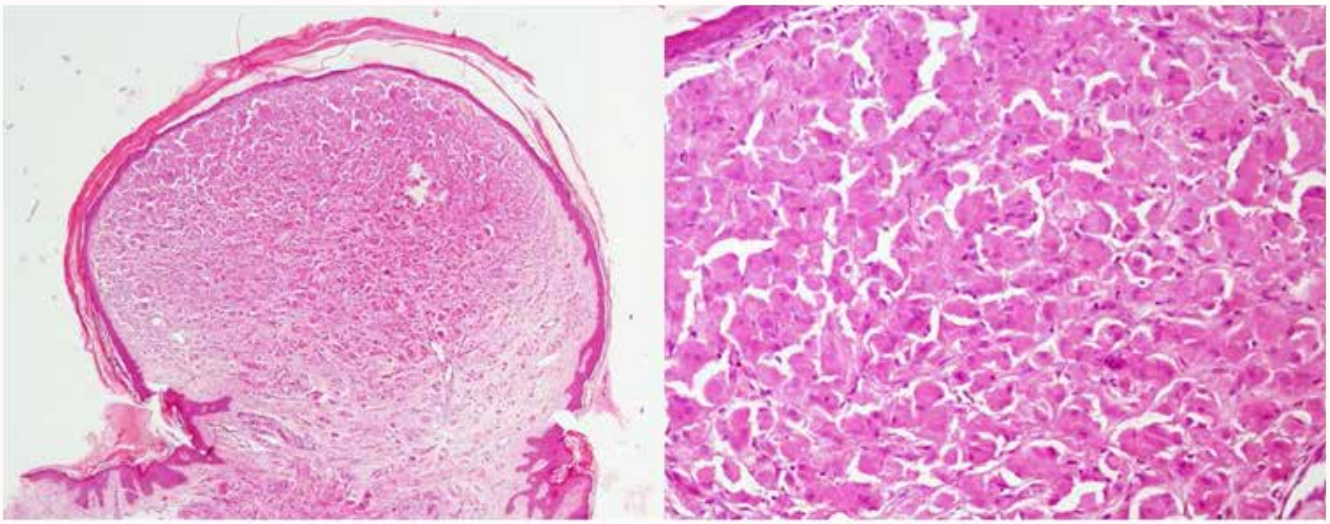

Figure 3

Case 4

A 43-year male presented with a verrucous lesion over his left knee. A punch biopsy was taken (Figure 4). What histochemical stains you can perform to highlight the round structures shown on the right side?

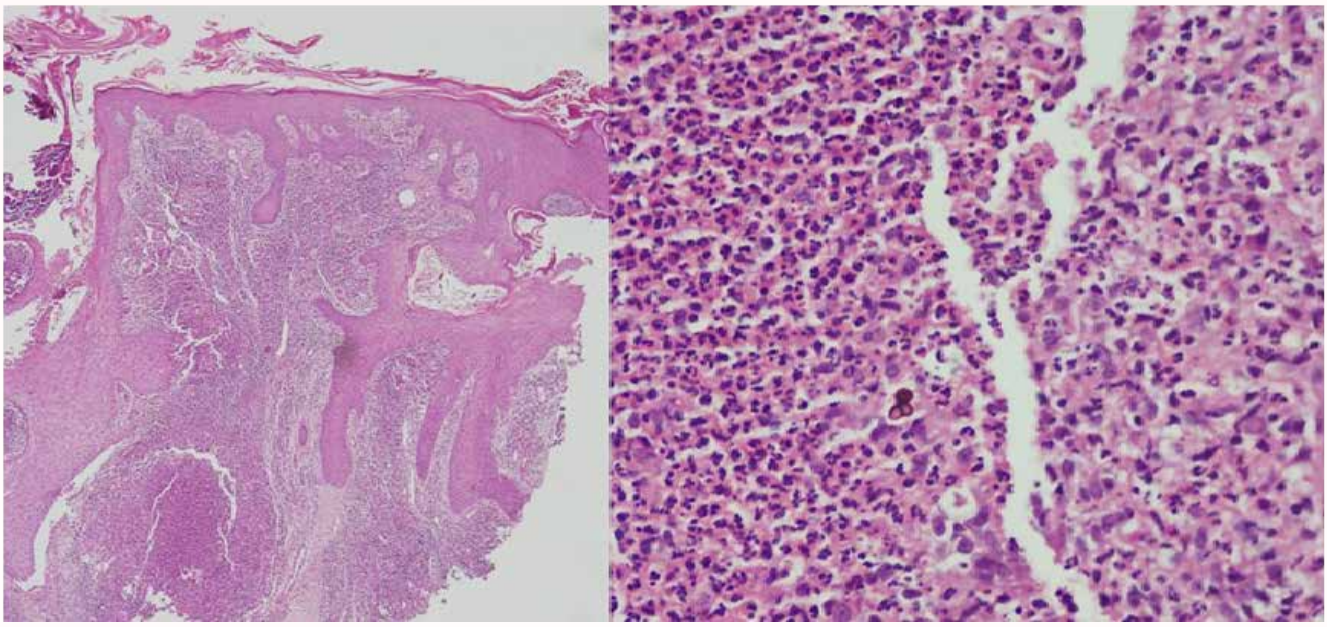

Figure 4

Case 5

A 7-year female presented with on and off abdominal pain and multiple purpuric lesions on bilateral lower limbs. She also gave a history of passing blackish urine for a few episodes. A skin biopsy performed is shown here (Figure 5). What do you expect from direct immunofluorescence (DIF) examination of the skin and kidney biopsies?

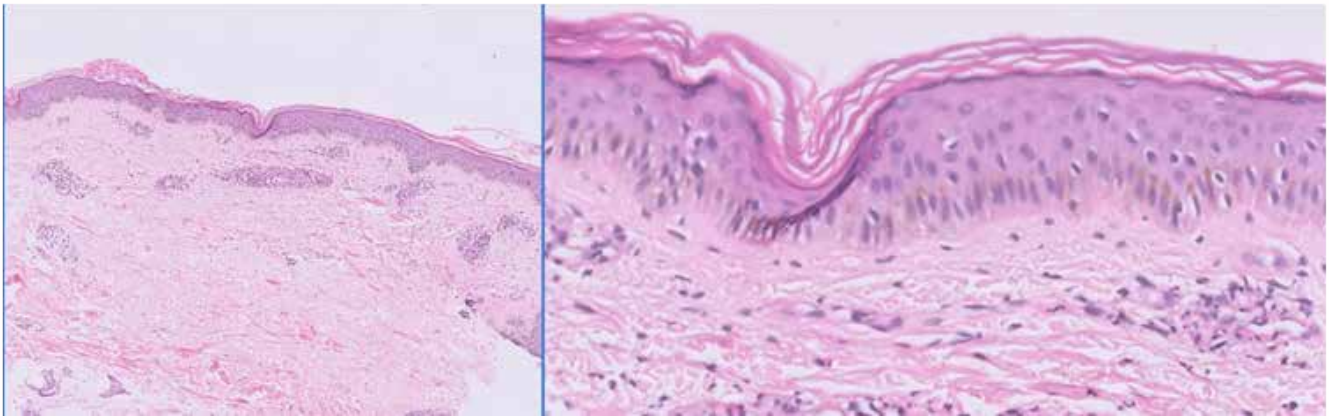

Figure 5

Case 6

A 62-year-old diabetic man presented with itchy erythematous dome shaped papules with central keratinous plug on his trunk and extremities (Figure 6) for last 6 months. Punch biopsy was taken. Name the key histopathological finding seen in this condition.

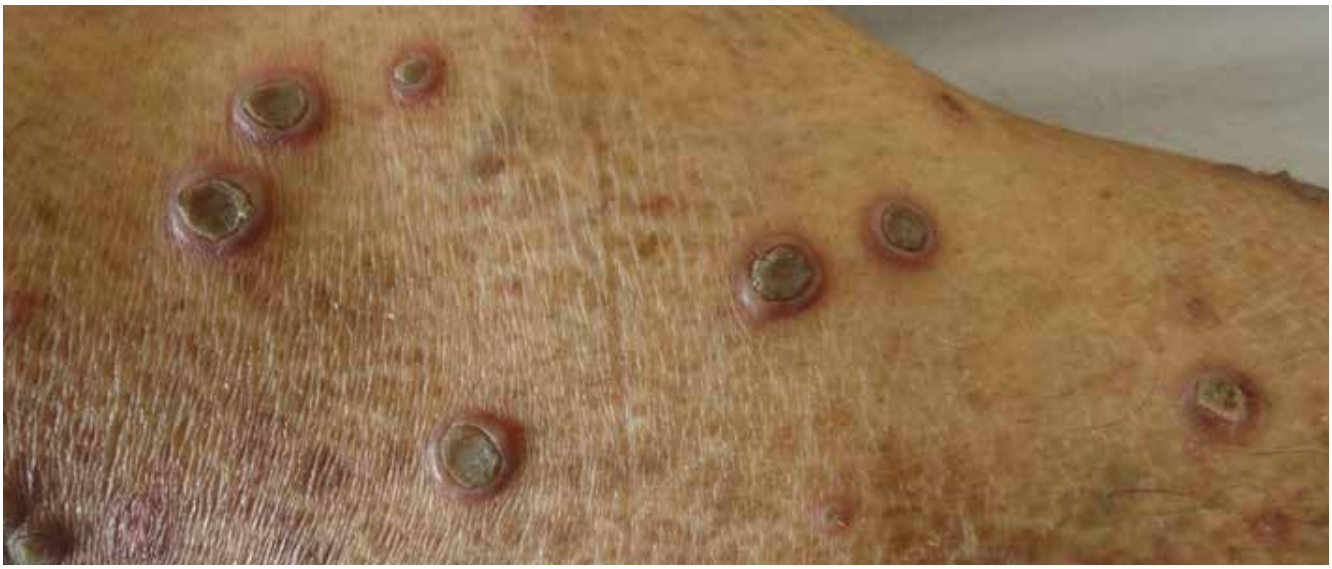

Figure 6

Case 7

A 45-year-old male presented with an erythematous moist plaque on his left thigh since 1 year. No history of bleeding from the lesion. Excision was done and histopathologic findings are shown (Figure7). What is the diagnosis?

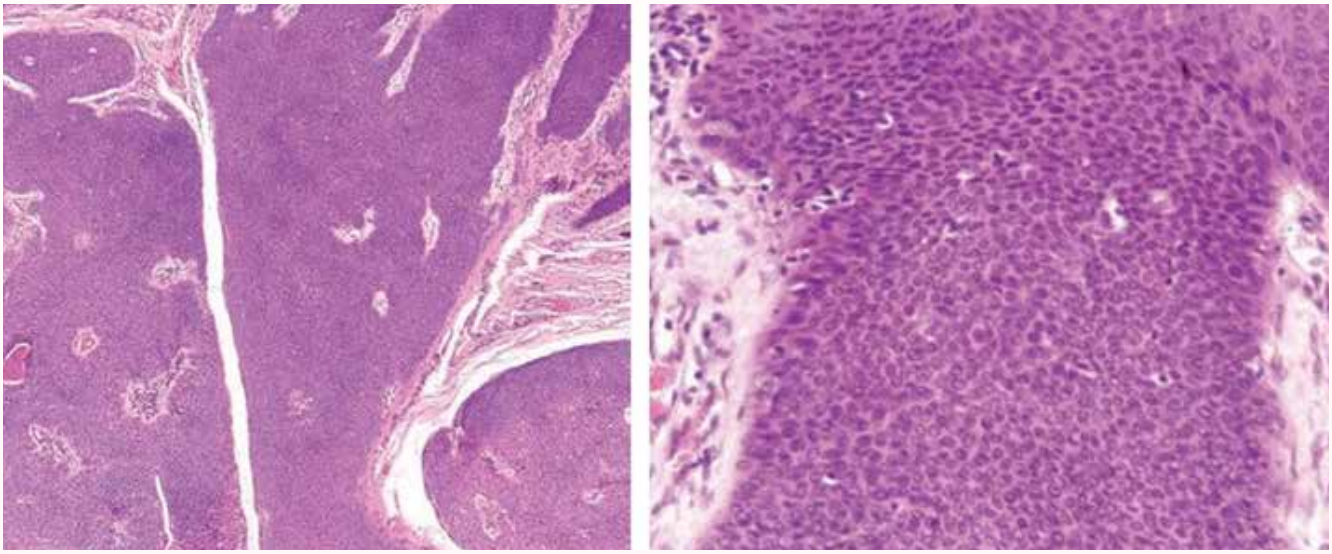

Figure 7

Case 8

A 18-year-old female presented with a skin-colored thickened elevated plaque on her left flank for 6 years (Figure 8). She also had few hypopigmented macules on the trunk and history of seizures. Biopsy was done from the plaque. Which stain will you perform to confirm the diagnosis?

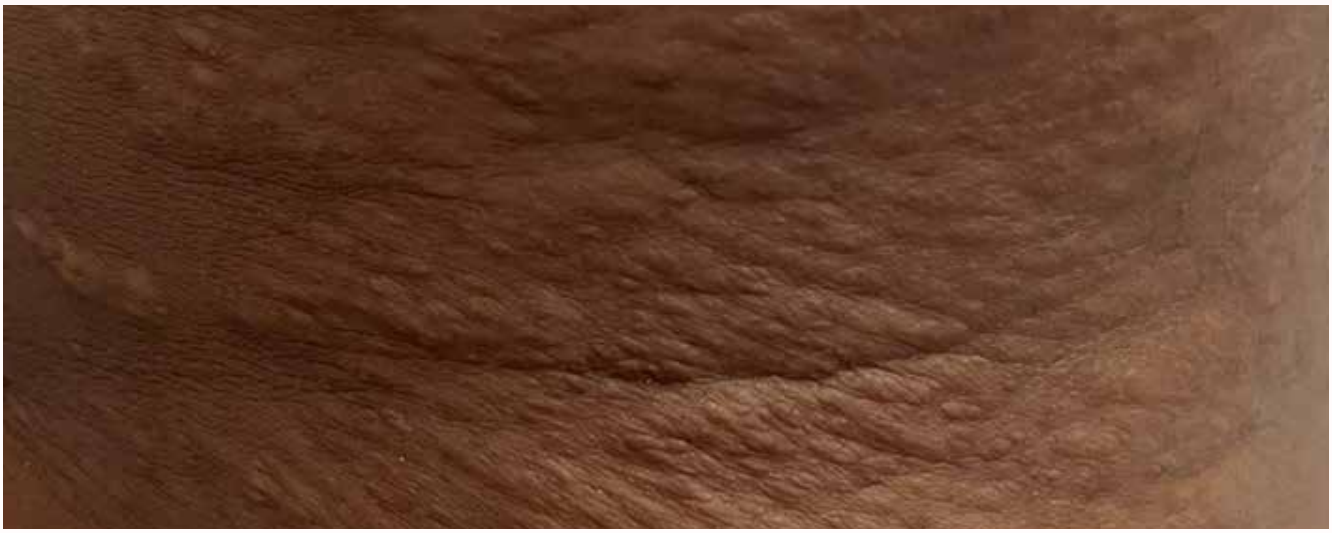

Figure 8

Case 9

A 5-year-old boy presented with a firm painless noduloplaque on the wrist for 4 months. Punch biopsy was taken (Figure 9). Spot the diagnosis

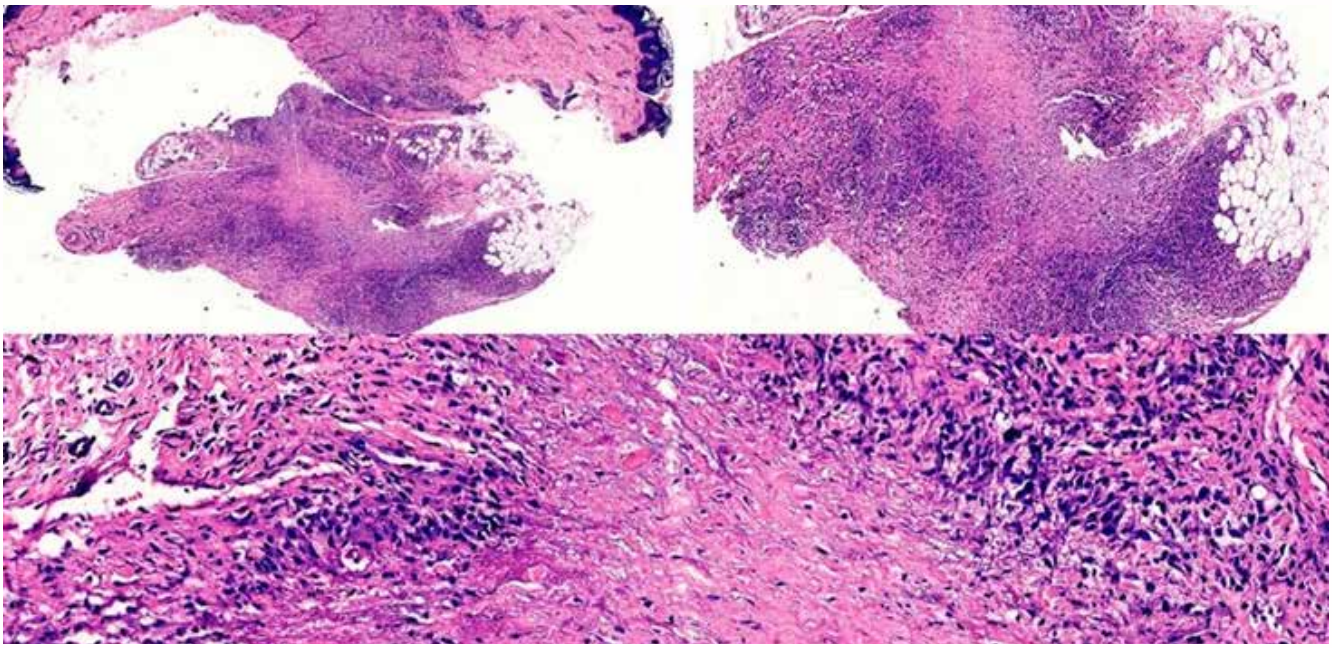

Figure 9

Case 10

A 50-year-old woman presented with extensive oral erosions for 1 year. She also gave history of fluid-filled lesions predominantly on her extremities, associated with loss of appetite and weight since 6 months. Biopsy was taken from the vesicle and from perilesional skin for DIF (Figure 10). What are the target antigens implicated in this condition?

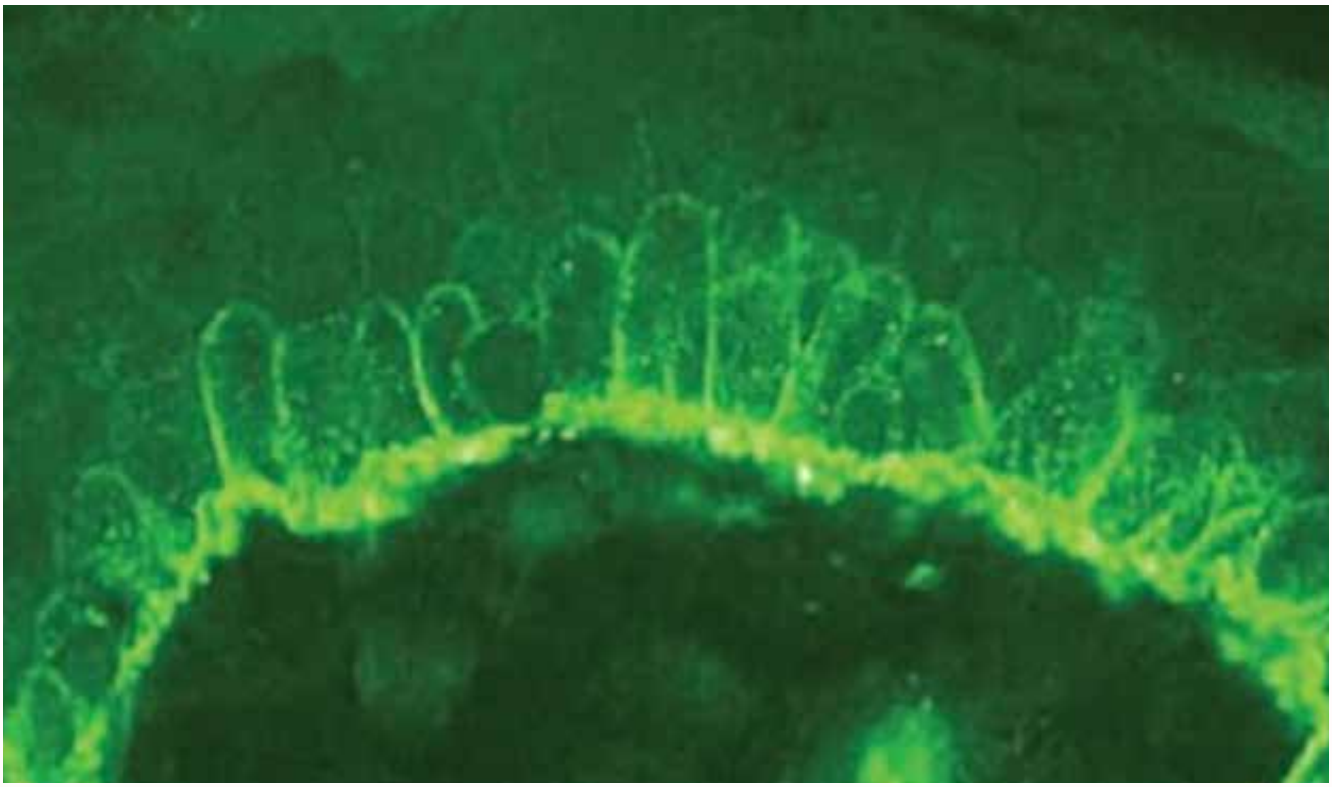

Figure 10

Answers for Quiz

1: The biopsy here shows the presence of enlarged keratinocytes in the superficial layers with enlarged nuclei and basophilic cytoplasm. Features are of epidermodysplasia verruciformis. It is an HPV-associated condition. These patients can develop cutaneous squamous cell carcinoma as a late complication.

2: This case shows sheets of atypical cells in the dermis. The immunohistochemistry indicates a metastatic carcinoma, possibly from the breast. Based on the histology and loss of e-cadherin, a possibility of metastatic lobular carcinoma (pleomorphic type) should be considered. Breast imaging

(mammography/ MRI) followed by core biopsy is required for the confirmation of the diagnosis.

3: Reticulohistiocytoma. The histology shows large epithelioid to polygonal cells in the dermis with abundant, eosinophilic, granular (oncocytic) cytoplasm. These are histiocytic cells, and negative for Langerhans cell markers (S100 and CD1a).

4: This case shows the presence of pseudoepitheliomatous hyperplasia of the epidermis, with the presence of multiple suppurative granulomas in the dermis. Some pigmented fungal spores (Medlar body or copper body) are also identified. These are pigmented fungi and contain melanin in their cell wall. These fungi can be better highlighted by periodic acid Schiff (PAS) stain (as magenta) and Masson's Fontana stain (as black).

5: The skin biopsy here shows the presence of leukocytoclastic vasculitis. Combining the history and the histology indicates an IgA vasculitis with IgA nephropathy. DIF of skin shows the presence of granular IgA deposition along the wall of the dermal capillaries and DIF on kidney biopsy shows granular IgA deposition along the mesangium of the glomeruli.

6: The lesions are suggestive of acquired perforating dermatosis. Histologically it shows transepidermal elimination of abnormal collagen fibres, inflammatory and keratinous debris through cup shaped invagination of the epidermis.

7: Eccrine poroma. Histology shows broad columns of small cuboidal monomorphic cells extending from undersurface of epidermis into dermis. These cells are united by prominent intercellular bridges and are well-delineated from the adjacent normal keratinocytes. Few ducts can be seen within the tumor columns (inset). Stroma is rich in vessels.

8: This is case of tuberous sclerosis showing shagreen patch. Shagreen patch is a variant of collagenoma. Histopathology demonstrates complete replacement of the dermis and sometimes subcutaneous fat by dense sclerotic bundles of collagen in interwoven pattern in the absence of any inflammation. Masson trichome stain shows bluish-green staining of collagen bundles, while Verhoeff-Van Gieson stain reveals markedly reduced or absent elastic fibers.

9: Deep/ subcutaneous granuloma annulare. Histology shows areas of necrobiosis in the mid and deep dermis extending to the subcutis. These areas are surrounded by peripheral rim of palisading histiocytes and lymphocytes. Increased mucin is seen in areas of necrobiosis/ altered collagen as basophilic stringy material.

10: This is a case of paraneoplastic pemphigus as DIF image shows IgG staining both in the intercellular spaces and linearly at dermo-epidermal junction. Autoantibodies are directed against various antigens such as envoplakin, periplakin, desmoplakin- I and II, plectin, desmoglein- 3 and BPAG-1.

Section 4

Basic Aspects of Dermatopathology for PG Residents

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Giant Cells

Introduction

In Dermatology giant cells have pathological significance and diagnostic value. They occur as a result of coalescing of multiple cells lineage to form multinucleated cells of varying morphology. The cell lineage could be either epitheloid cells, macrophages ,melanocytes, epithelial cells and so on. Cells are large in size and are found in chronic granulomatous conditions and site of inflammation.

Morphology

Phenotype of multi-nucleated giant cells varies depending on the local environment and the chemical and physical (size) nature of the agent to which the macrophage-derived giant cells (MGCs) and their monocyte/macrophage precursors are responding.[1] The size of giant cells varies greatly, but is usually between 40 µm and 120 µm.[2] In chronic inflammation when the macrophages fail to deal with particle to be removed, they fuse together and form multi-nucleated giant cells.[3] These cells contain 15-30 nuclei which are arranged in different patterns in different type of giant cells. Other cells which can also form giant cells are keratinocytes, melanocytes, etc.

Giant cells seen in Dermatology [4]

1. **Macrophage derived**

a. Langhans' giant cells

b. Foreign body giant cells (FBGCs)

c. Touton giant cells: Xanthelasmatic giant cells

2. **Epidermal cell derived**

a. Tzanck giant cells

b. Multi-nucleated epidermal giant cells

3. **Melanocyte derived**

a. Starburst giant cells

b. Giant cells in melanocytic nevus

- Balloon cells
- Giant nevus cells

4. **Other giant cells**

a. Floret-like multi-nucleated giant cells (FMGCs)

Langhans giant cells

Langhans' giant cells have horse shoe-shaped nuclei arrangement at one pole of cell. These giant cells are seen in granulomatous conditions especially in tuberculosis. Interactions with cluster Differentiation 40 and its ligand (CD40L) as well as interefron gamma are essential for the formation of Langhans' giant cells.

They are seen in Tubercular granuloma, Leprosy (TT Type mainly),Late Syphilis, Deep fungal infection, Sarcoidosis, Leishmaniasis, Crohn's disease (Figure 1,2,3).

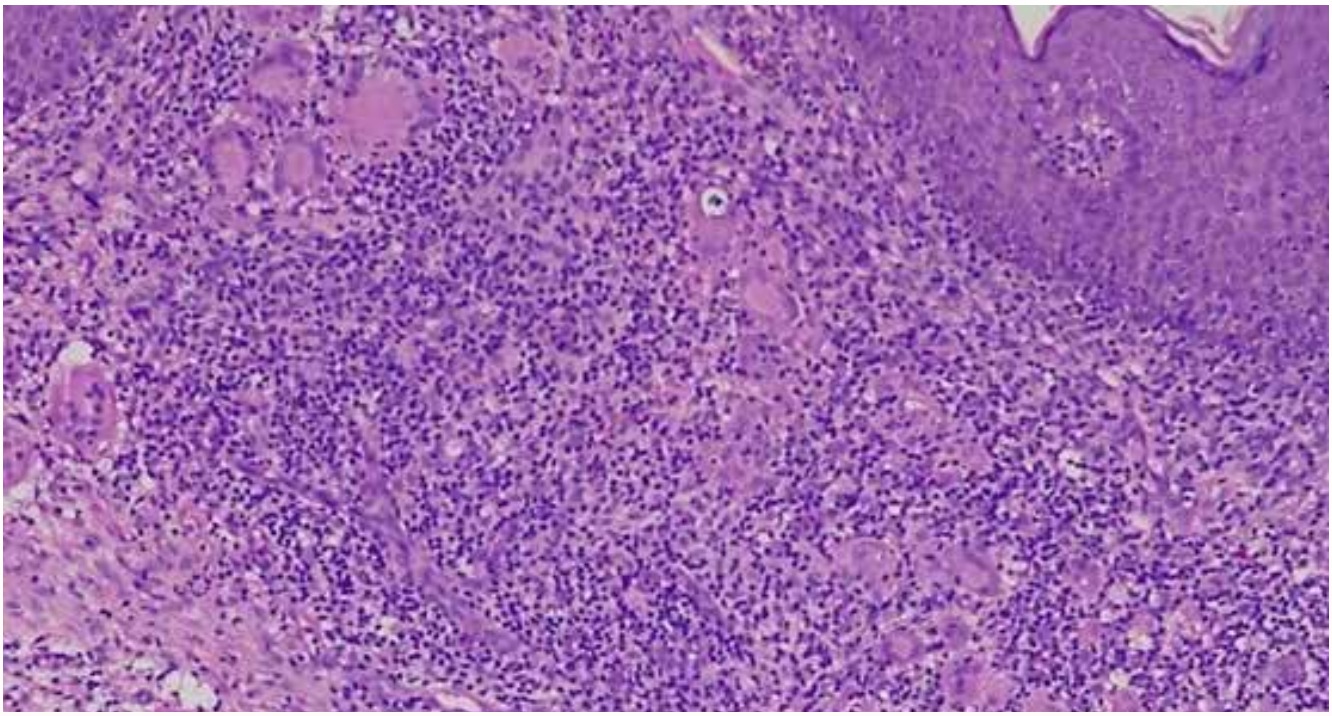


Figure 1: H&E 100X (Image courtesy Dr Subhra Dhar)

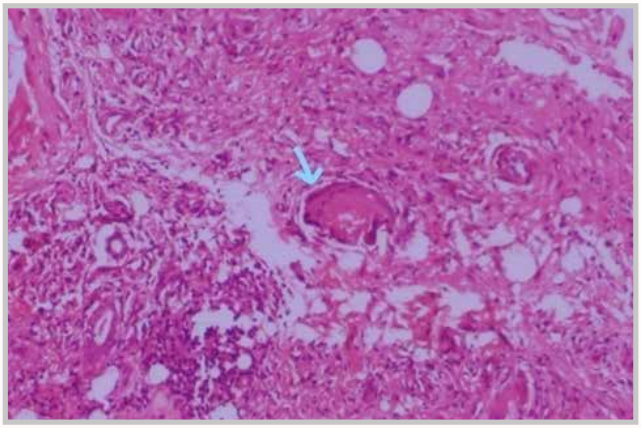


Figure 2: H&E 100X (Image courtesy Dr Sanjana A S)

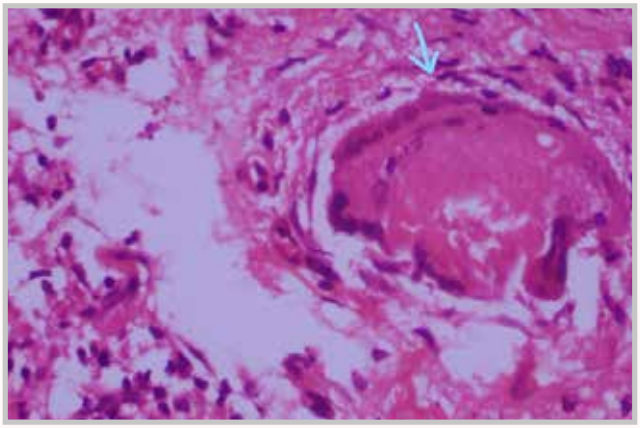


Figure 3: H&E 400X (Image courtesy Dr Sanjana A S)

Foreign body giant cells

Foreign body giant cells (FBGCs) have nuclei randomly scattered throughout their cytoplasm. It results from the body's attempt to remove the impregnated foreign material.[5]. Recent studies show that macrophage fusion, giant cell formation, and the foreign body response require matrix metalloproteinase 9(MMP-9)[6]

They are seen as a response to endogenous or exogenous materials. Endogenous are calcium deposits, urates, oxalate, keratin, and hair. Exogenous particles are starch, talc, tattoo material, cactus bristles, wood splinters, suture material, injected hyaluronic acid, pencil lead, bovine collagen.

These giant cells are also seen in Borderline tuberculoid type of leprosy.[7,8] (Figure 4)

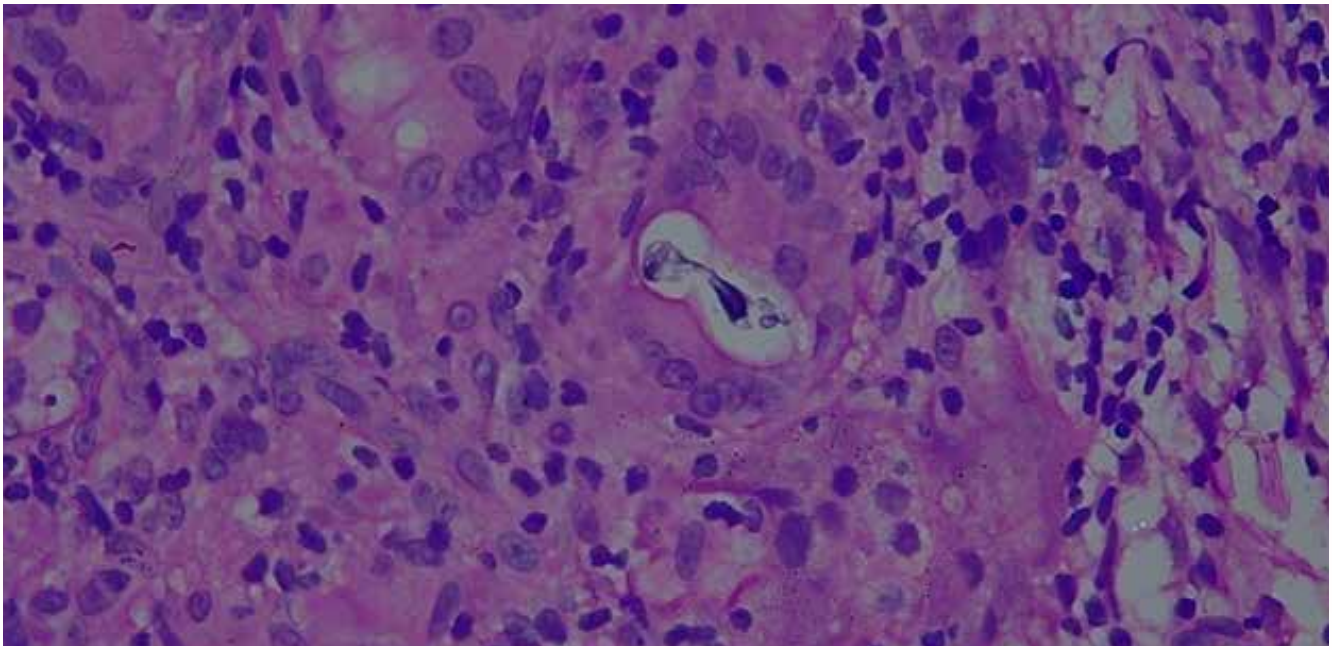


Figure 4: H&E 400X (courtesy Dr Subhra Dhar)

Touton giant cell

It is proposed that Touton cells develop when the stimulus to cell fusion is accompanied by a factor stimulating lipid uptake. Touton giant cells have a central ring of nuclei while the peripheral cytoplasm is clear due to accumulated

lipid.[5] They are seen in Fat necrosis, Xanthoma, Xanthogranulomas and Dermatofibroma (Figure 5).

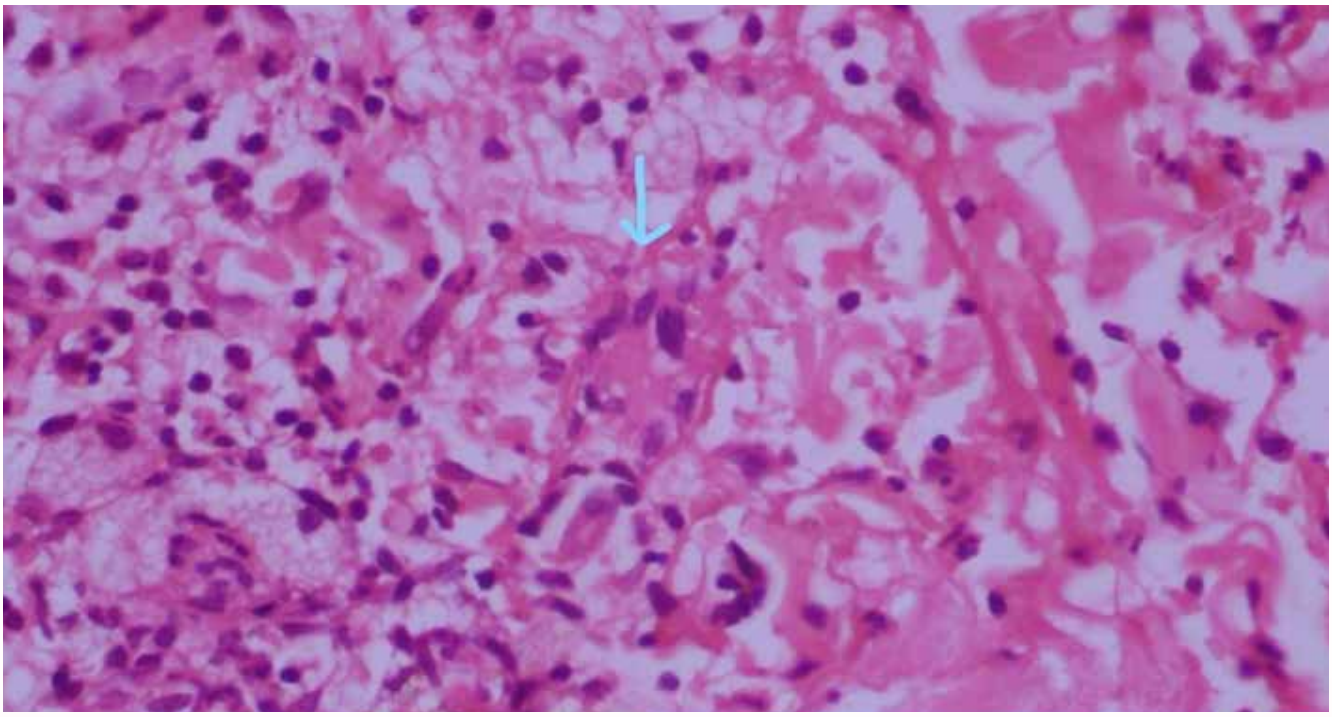


Figure 5: H&E 400x (courtesy Dr Sanjana A S)

Epidermal derived giant cells

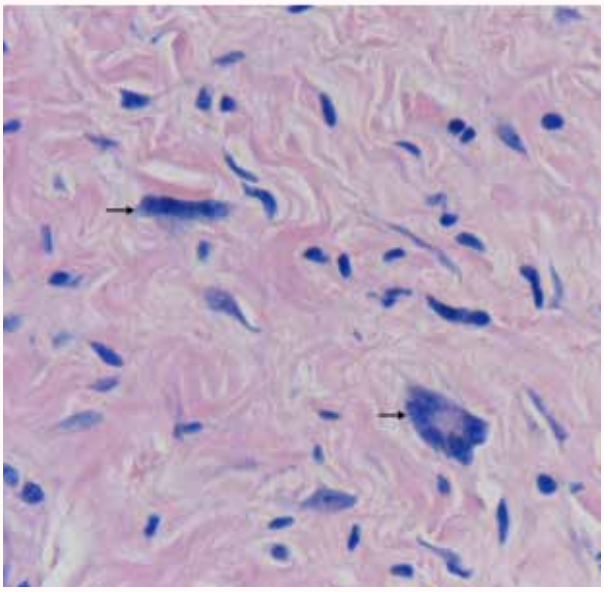
Tzanck giant cells

It is named after Arnault Tzanck, a French dermatologist. Viruses cause abnormal cell division in epidermal cells, and this creates multi-nucleated giant cells. These are epidermal cells that are much larger than the normal epidermal cells.[9]. These cells are seen in Herpes simplex, Varicella and Herpes zoster and Cytomegalovirus.

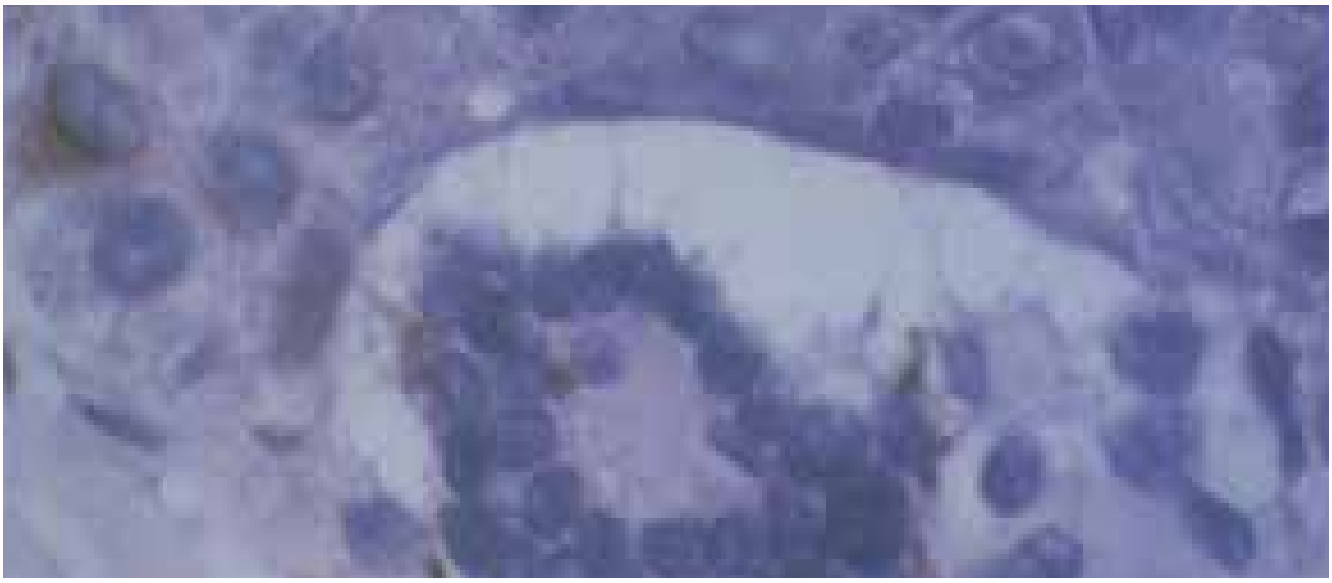
Multinucleate giant cells

The multi-nucleated epidermal giant cells (MEGCs) have more than three clumping nuclei . These are giant cells formed by epidermal cells in response to various types of inflammation.[10] These giant cells are seen inChronic eczema or prurigo, Lichen amyloidosis, Dermatitis herpetiformis, Erythema multiforme, Pustular psoriasis ,Lichen planus and Lupus erythematosus.[11,10]

FLORET-LIKE MULTINUCLEATED GIANT CELLS IN NEUROFIBROMA (FMGCs)



FMGCs have scanty cytoplasm and peripherally arranged nuclei in the intervening stroma. These are positive with vimentin and CD-34 and negative with S-100 and CD-68. The FMGCs may be mesenchymal or fibroblastic in origin. FMGCs have been described in soft tissue tumours like Gynecomastia, Neurofibroma in NF-1, Giant cell angiofibroma & Pleomorphic lipoma.



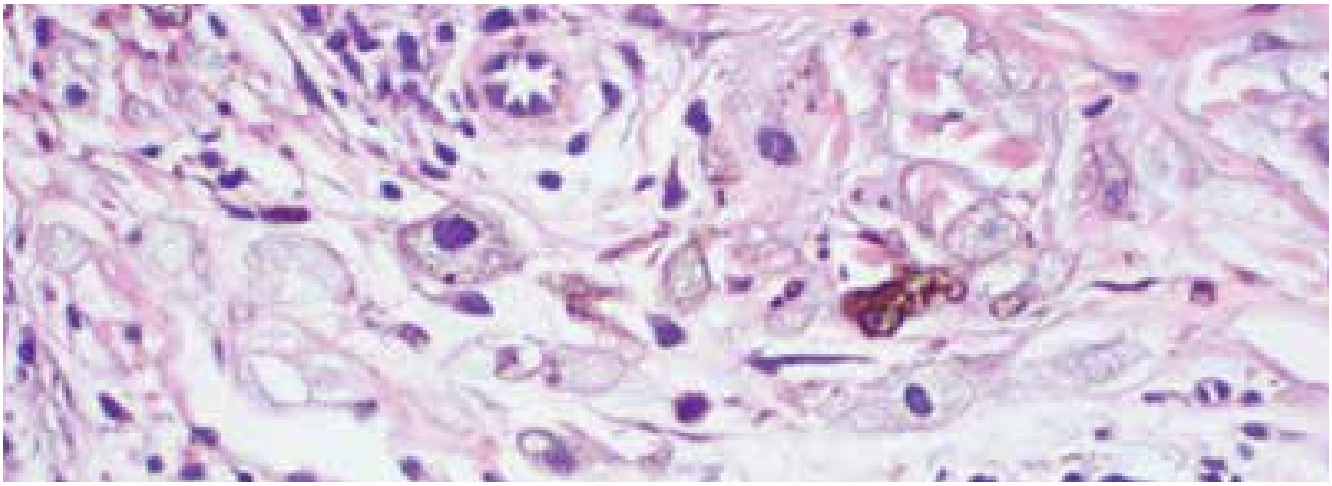
The SGC is located along the basal cell layer and contains prominent dendritic processes, a wreathlike distribution of numerous nuclei, and eosinophilic glassy cytoplasm. Their nuclei were described as round or ovoid with variable numbers of nucleoli, arranged in a circular pattern. The SGC is a sensitive and specific marker for Lentigo Maligna (LM). If there are four or more nuclei, the lesion is 61.8 times more likely to represent LM. There are two hypotheses regarding the formation of multinucleated melanocytes, namely, fusion of individual melanocytes or nuclear division (mitosis or karyokinesis) without cell division (cytokinesis).[12]

CELLS IN NEVUS

a) GIANT NEVUS CELLS

These cells are multi-nucleated and bizarre in shape. The cells resembled Touton giant cells in one case. Presence of this cell is one of the minor diagnostic criteria of Spitz nevus. These are also seen in melanoma but nuclei are more pleomorphic, while in Spitz nevus, nuclei are regular and similar in size. [13]

b) BALLOON CELLS



Balloon cells are considered altered melanocytes formed by progressive vacuolization due to the enlargement and disintegration of melanosomes. They are comparatively larger in size with centrally placed, small, round, deeply basophilic nuclei and clear, foamy, well-demarcated cytoplasm. Balloon cells may present with or without abundant pigmentation. When balloon cells represent ≥50% of the melanocyte constituency within a nevus, the lesion is called a balloon cell nevus (BCN). Theories suggest that the large number of melanosomes represents a proliferative process, or it is caused by arrest in the biosynthesis of melanin in the melanosome as an intrinsic cellular degenerative process. Balloon cell change of the melanocytes has been described in both malignant and benign entities. It has been described in melanoma of the skin, choroid, and conjunctiva. Its been reported in benign nevi including Spitz nevi, combined nevi, halo nevi, dysplastic nevi, and nodal nevi. [14]

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Section 5

Interesting Titbits/conundrum In Dermatopathology

Hypopigmenting Dermatitis as a clinicopathologic designation for unclassifiable benign hypomelanosis: a viewpoint

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Modern medicine is ever changing with addition of newer disorders almost keeping pace with the rapid technological advancements. The beauty of cutaneous medicine lies in the fact that most disorders are classified on the basis of precise naked-eye morphologies despite unknown pathogenesis. However, sometimes it proves to be a bane as not all dermatoses that are clinically similar share etiological proximity. Consequently, advances in laboratory techniques gradually unravel etio-pathogenesis and have the power to modify description based classification. Even then, descriptive dermatology is of great value in ushering novel entities and resolving diagnostic and therapeutic conundrums.

Hypopigmented lesions are commonly seen in dermatology outpatients in India due to obvious psychosocial stigma that they generate. Clinical appearance in the form of multiple hypopigmented macules can be seen in several dermatoses

and few causes relevant to India include early vitiligo, congenital/genetic causes (nevus depigmentosus, ash-leaf macule), eczematous causes (childhood atopic dermatitis, seborrheic dermatitis, pityriasis alba), hypopigmented sarcoidosis, infective causes (leprosy, post kala azar dermal leishmaniasis, pityriasis versicolor), pityriasis lichenoides (PL), hypopigmented polymorphous light eruption, progressive macular hypomelanosis, parapsoriasis, hypopigmented mycosis fungoides, chemical/drug induced hypomelanosis, idiopathic guttate hypomelanosis and finally post-inflammatory hypopigmentation secondary to any inflammatory dermatoses. Indeterminate leprosy (IL) is a variant which present with ill to well defined hypopigmented macules with hair loss. Biopsy reveals predominantly perineural and peri-appendageal inflammation without granuloma formation and may not show presence of acid fast bacilli, which often leads to diagnosis being missed. Similarly, hypopigmented macules of PKDL commonly show non-specific perivascular and peri-appendageal inflammation and often lack amastigote forms. Both IL and PKDL are diagnosed on clinicopathologic correlation.

But many such lesions do not fit classically described entities. One such subset has been described as macular hypopigmentation, hair loss and follicular spongiosis and makes for interesting reading as it is reasonably difficult to be convinced about a novel clinico-pathologic entity and sufficiently more arduous to persuade the scientific community to accept it. The authors found the combination of these clinicopathological features to be unique and proposed the designation of “truncal pityriasis alba” or “hypopigmenting dermatitis” for the entity.[1] On the other hand, intermittently we see some patients reporting with ill-to well defined hypopigmented non-scaly macules over trunk without any history of facial involvement or atopic tendencies. Traditionally such cases have been termed as extensive pityriasis alba and there features seem non-specific even after histopathology and immunohistochemistry.[2] In view of unknown etiology of hypopigmentation, such cases may be housed under the ambit of this term of “hypopigmenting dermatitis”.

From a histopathologic viewpoint, any dermal inflammation is defined as a

reaction pattern of 'dermatitis' and the usage of latter term may not essentially reciprocate the clinical terminology which indicates eczema only. Therefore if we consider clinical plus pathologic usage in the term hypopigmenting dermatitis, a host of other unusual conditions come to mind under the heading of cutaneous T cell duscrasias (CTCDs). Syringolymphoid hyperplasia with alopecia is a CTCD that has been reported to have hypopigmented lesions with alopecia and follicular prominences as well in addition to its classical morphology of erythematous plaques. Histologically, it shows inflammation of both follicular as well as sweat duct epithelia.[3] Similarly, another rare entity in the same group of CTCDs is folliculotropic T-cell lymphocytosis. Although it usually presents with erythematous patches or plaques, hypopigmented lesions with follicular prominences and alopecia have been mentioned. Histologically, it is characterized by inflammation centred on the follicles.[4] Hypopigmented interface T-cell dyscrasia (HITCD) is yet another group among the CTCDs which comprises of lesions which do not fulfil the criteria for early mycosis fungoides and may show follicular prominences. The T-cell inflammation is primarily at the dermo-epidermal junction but few cases with folliculotropic inflammation have been described.[5] Finally, unusual reports of alopecia mucinosa have also been described in literature to present with hypopigmentation and follicular papules with a biopsy finding of folliculocentric inflammation and mucin deposition.[6] The hypopigmented phase of pityriasis lichenoides may not reveal characteristic histopathologic changes and if often diagnosed on clinicopathologic correlation only.

To summarise the above discussion, creating a miscellaneous category of 'hypopigmenting dermatitis' may be helpful by including all the other dermatosis which do not show features classic of known entities and remain unclassified despite clinical deliberations and adequate efforts at investigations. Eventually, long term follow up and sequential biopsies resolve the diagnostic dilemma in a subset of disorders with hypopigmentation. As in most other circumstances in clinical dermatology, clinicopathologic correlation is of paramount importance.

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Section 6

Snippets From SIG Dermatopathology, CMEs Conducted And News Regarding Future SIG Activities

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Aims achieved

1. Four "Dermatopathology workshop-cum-CME" were successfully conducted physically in Delhi (on 9th April 2022), Shillong (on 29th and 30th April 2022),Ahmedabad, Gujarat (on 29th May 2022) and Lucknow (10th December 2022).

   Highlights of workshop-cum-CME were slide viewing and discussion, didactic lectures on wide range of topics pertaining to dermatopathology by experts in field of dermatology and pathology, interesting dermatopathology case discussions, quiz and international online lecture on the role of "Pathpresenter as a useful resource in dermatopathology." All were highly appreciated by PGs and delegates.

CME: DELHI (9th APRIL 2022)

CME: SHILLONG (29,30th APRIL 2022)

CME: AHMEDABAD, GUJARAT(29th MAY 2022)

CME: LUCKNOW (10th DECEMBER 2022)

2. From May to December "Image of the month" was uploaded with enthusiastic responses from IADVL members.

3. Digitalized 20 classic histopathology slides for postgraduate teaching and learning and uploaded on IADVL website.

Activities initiated and completed

1. First SIG dermatopathology newsletter

Activities planned

1. Conduct CME-cum-workshop at Eluru, Andhra Pradesh in February 2023
2. Virtual dermatopathology quiz for PGs to be conducted in January 2023
3. Establish concrete collaboration between IADVL and "PathPresenter"
4. Conduct CME on Dermoscopic-Histopathologic Correlation with SIG Dermoscopy in April 2023.
5. Review article on dermatopathology pertaining to PGs

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