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# From The Diary Of A Dermatopathologist

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## Abstract

### DEAR EDITOR

Over the last 30 years, I have been studying and learning about skin pathology, and. I have had many interesting experiences. Let me share a few of my stories with you.

### AIDS AND MOLLUSCUM CONTAGIOSUM

The year was 1981. We had heard about five gay men from Los Angeles who developed pneumocystis pneumonia, a disease usually seen in immunosuppressed patients. A few reports of other opportunistic infections, such as, CMV and candidiasis, occurring in gay men started appearing. Initial idea was that the gay life style somehow depressed the immune system of these men making them vulnerable to infections; GRID (Gay Related Immune Deficiency) was the name initially given to this disease, but soon after, the name changed to AIDS (Acquired ImmunoDeficiency Syndrome), because many new patients were not gay, and some developed the disease after receiving blood transfusion. Then in 1985, we learned that a virus, HIV (Human Immunodeficiency Virus) was the cause of AIDS.

Early in 1985, I received three skin biopsies from the face of a 39-year-old gay patient recently diagnosed with AIDS. Microscopically, all the lesions were molluscum contagiosum, (caused by a poxvirus). A search in Index Medicus yielded no report of such an infection in AIDS. I quickly reported the case to the Journal of American Academy of Dermatology and claimed it to be the first such case [1]. Later, I found out that there were four (including mine) published reports of molluscum contagiosum in AIDS in 1985.

### INFANTILE DIGITAL FIBROMATOSIS, INCLUSION BODY FIBROMATOSIS

The lesion is a benign fibroblastic tumor occurring in infants, and is typically located in the fingers or toes. On microscopy, the spindle shaped fibroblasts show the presence of unique intracellular hyaline inclusions. The

possible viral etiology has never been established. The resected lesion may recur or may even regress if left untreated.

In 1976, I was reading a skin biopsy showing a dermal spindle cell proliferation. The cells looked benign. The most interesting observation was the presence of red hyaline intracytoplasmic inclusion bodies. My immediate thought was some sort of viral infection. I could not find anything in the book that resembled this lesion. My colleague (Hoffmann) studied the inclusions with electron microscopy and concluded that they were not viral inclusions. He took the case to one electron microscopy conference where other pathologists looked at the case. Their conclusion was 'looks like infantile digital fibromatosis'. My problem was "the patient is 44 years old, far from being infant!... the lesion is located over the left upper arm, far from the digits!" I did several special stains... read everything about infantile digital fibromatosis. Finally, I concluded that the case I was looking at was the first case of this inclusion-bearing fibromatosis occurring in an adult at a non-digital site [2, 3].

Since my report, a few additional cases of this type of fibromatosis occurring in adults at non-digital sites have been published. I was fascinated to know that the lesion has been seen at other locations, such as, the tongue and breast. The name infantile digital fibromatosis remains popular. However, "Inclusion body fibromatosis" would be a better descriptive name.

### BASAL CELL CARCINOMA MARGINS

At a 1984 weekly dermatology conference attended by a dozen of residents and 4-5 dermatologists, a

resident asks me, "Dr. Sarma, on the basal cell cancer excisions, you report out positive margins,... then we re-excise the previous site, and then you tell us that there is no residual tumor. What happened to the tumor that you said was in the margin? How often do you really see any residual

tumor?" I responded, "Not too often! Well, I really don't have a percentage to give you, but will find out. Now, what happened to the tumor? Good question. I have to read up on it"

My literature search failed to find any specific information about how often the re-excised skin shows tumor. So, to save face with the residents, I had to find the number from my own work. After looking at 43 cases of re-excised skin with previous positive margins, I found the magic number. In my series, residual basal cell cancer was detected in 7% of the cases [4]. This observation has remained the same over all these years. What happens to the tumor that we see at the first excision margin? My speculations are: tumor extends up to the margin and but not beyond, tumor cells die out at the site because of inflammatory response, tumor cells are not detectable in the midst of repair and inflammation. Even though in 90% of the re-excised specimen, residual tumor is not seen, re-excision of a margin-positive basal cell carcinoma is definitely indicated. In the absence of re-excision, the recurrence rate may be as high as 35% over a 5-year follow-up period, most of them within 24 months.

### **A PERSONAL COMMENTARY**

In surgical pathology, the specimens that the pathologists receive are quite varied, ranging from small biopsies or larger samples, such as, resected tissues and organs with various lesions. We routinely perform

- a) a gross examination of the specimens followed by a microscopic examination of the entire sample of the
- b) small biopsies and carefully selected samples from the larger specimens.

In dermatopathology practice, except for the large skin tumors, we are completely dependent on the submitting clinicians for the gross observations.. We receive a punch, shave, or curetting for microscopic evaluation. In these cases, the clinician becomes our partners as the clinician-

gross pathologist, and we are the microscopists. Give us a good clinical history, a description of the lesion, and your diagnosis or a differential diagnosis, and we will try our best to correlate your findings with our microscopic findings.

Yes, for many non-neoplastic inflammatory and non-inflammatory dermatoses, we may not have a specific diagnosis, but with your clinical input, we surely can reach a reasonable assessment of the lesion.

The pigmented lesions of the skin are problematic for all of us. You, the primary physicians are in the best position to identify the early or suspicious pigmented skin lesions. A mole that is enlarging, bleeding, ulcerated, or changing color should be biopsied. Although many of the biopsies will be benign (e.g. melanocytic nevi, lentigo, seborrheic keratosis etc), without a biopsy, a highly atypical nevus or an early melanoma may be missed along with an opportunity to prevent a dangerous disease.

I agree with Dr Bernard Ackerman's opinion that nobody should die from malignant melanoma of the skin [5]. Early detection is the key!

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