cellular migration) in epidermal keratinocytes following treatment with C225. This is related to a change in the in vivo regulation of follicular and epidermal homeostasis mediated by EGFR, leading to the appearance of the acneiform eruption.\textsuperscript{3,5,12,13}

Cultures fail to show an infectious agent as the cause of the eruption, a factor which supports the diagnosis.\textsuperscript{5,8,9} The histopathologic study of the lesions shows a follicular reaction consisting of an intense neutrophilic inflammatory infiltrate surrounding the infundibuli,\textsuperscript{5,12} which sometimes appear hyperkeratotic.\textsuperscript{6} A differential diagnosis should be established with rapid-onset follicular eruptions, whether they are established entities or drug reactions; among the most common drug reactions are those produced by vitamin B\textsubscript{12}, corticosteroids, androgens, lithium, tuberculostatic drugs, halogens, some tricyclic antidepressants, anticonvulsive drugs, and immunosuppressors. The eruption usually responds to tetracyclines such as minocycline at 100 mg/d, or doxycycline at the same dose. Currently no consensus exists as to the duration of treatment.\textsuperscript{3,9,10,14} Recurrence is relatively frequent, although less intense than the initial episode. In view of the increased use of biological therapy in a variety of specialties, we can expect to see this entity with increased frequency in everyday dermatological practice. Dermatologists should therefore consider it as soon as the patient’s history is taken, thus avoiding invasive tests such as biopsy in many cases. Tetracyclines are currently the treatment of choice and there have been few reports of therapeutic success with alternatives such as metronidazole, used in the present case, or other systemic antibiotics.

References

Solitary Congenital Plaque-Like Telangiectatic Glomangioma

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To the Editor:

Glomus tumors comprise a group of relatively rare neoplasms. They may be either solitary or multiple. The latter constitute less than 10% of all cases, and in the traditional classification they were divided into disseminated and localized forms.\textsuperscript{1,2} In 1990, another form, called congenital multiple plaque-like glomus tumors, was described by Landthaler et al.\textsuperscript{3} Subsequently, in 1998, Requena et al\textsuperscript{4} described a rare variety
A 41-year-old woman with a history of lichen sclerosus in the genital area and cholecystectomy was referred to our department for evaluation of an asymptomatic lesion on the left scapula that had been present since birth. The patient reported that the size of the lesion had increased proportionally as she grew, without further change except for a slight “sinking” in the previous 4 years. She reported no family history of similar lesions.

Physical examination revealed a well-circumscribed telangiectatic plaque located on the left scapula; the plaque was 9 × 4 cm in diameter and depressed with respect to the adjacent skin (Figure 1). No other skin lesions were present.

An x-ray of the left scapula showed no significant changes, and a biopsy of the lesion was performed. The histopathologic study showed vessels in the reticular dermis that were dilated (Figure 2), with endothelial cells surrounding the lumen that were in turn covered by several layers of glomus cells (Figure 3). In the immunohistochemical study, the glomus cells were positive for smooth muscle α–actin and vimentin, and negative for expression of desmin and CD34 (Figure 4).

Glomus tumors are divided into 2 clinicopathological variants, solitary and multiple, which have different distribution patterns, gross morphology, and histopathology.

Solitary glomus tumors are the most common variety and often cause a sharp pain in response to pressure or exposure to cold. They usually appear in adulthood on the distal parts of the limbs, especially in the nail beds. Histopathology shows a well-circumscribed nodule composed of groups of glomus cells surrounding small vascular spaces covered with endothelial cells.1,2

Multiple glomus tumors, also called glomangiomas because of their angiomatosus appearance or glomuvenous malformations, appear earlier, are usually painless, and are generally inherited as an autosomal dominant disease. In general, these lesions are less well demarcated and have far fewer glomus cells than solitary glomus tumors.1,2,5 This variant is divided into 3 types: (1) multiple disseminated glomangiomas, characterized by lesions of solitary glomangioma consisting of an acquired telangiectatic plaque on a woman’s shoulder. We present a case of solitary congenital plaque-like glomangioma with a telangiectatic surface recently seen in our department.

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Angiolipomas and Antiretroviral Therapy

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To the Editor:
In recent years, an association has been described between the use of protease inhibitors for antiretroviral therapy and the appearance of angiolipomas and lipomas, as well as with an increase in the number and size of those already present.1-3

A 40-year-old man consulted in 2005 for lesions that first appeared in 1998, and that had increased in number and size since then. Some were tender to pressure or spontaneously painful, while others were asymptomatic. The patient, a former intravenous drug user, tested positive for hepatitis B, C, and D, and for the human immunodeficiency virus (HIV). He had started antiretroviral treatment with lamivudine, zidovudine, and indinavir in 1998, and in 2001 indinavir was substituted with nelfinavir; however, the lesions continued to appear. He reported no family or personal history of similar lesions.

Physical examination revealed numerous subcutaneous tumors on the upper limbs and, to a lesser extent, on the trunk and lower limbs. These were clearly circumscribed, firm, and, in some instances, painful to the touch (Figure 1).

References