In this case, the differential histopathological diagnosis should be made with:

1. Skin metastases of internal neuroendocrine tumors such as small-cell lung cancer. In our case, the positive assay for cytokeratin 20 and the negative one for TTF-1 ruled out this tumor, an exclusion that was also supported by the lack of pathological findings on the plain chest X-ray.[7]
2. Primary neuroendocrine adenocarcinoma of the breast. This term is reserved for uncommon breast tumors in which more than half the cells express neuroendocrine markers (NSE, chromogranin A, or synaptophysin) and which present mainly in elderly women. This would perhaps be the main tumor to rule out here given that the site of the tumor in our patient was the breast, particularly as some reports indicate that superficial biopsies have led to initial misdiagnosis.[9,10]

Conflicts of Interest

The authors declare no conflicts of interest.

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Molluscum Contagiosum Over a Tattoo

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To the Editor:

In our daily practice, consultations for tattoos and associated dermatological complications are increasingly common. This ancient practice is currently becoming more widespread among the general population, and there are an increasing number of reports of dermatological processes associated with tattoos in the literature; these complications include contact dermatitis, local and systemic infections, transmission of hepatitis C and B virus (HCV and HCB), human immunodeficiency virus (HIV), syphilis, warts, and cutaneous tuberculosis.[1,2]

We report here our experience with this type of problem. A 36-year-old man consulted for several umbilicated papules measuring 1 to 3 mm in diameter on a black-ink tattoo on the right arm (Figures 1 and 2). Since he first had the tattoo several years earlier, no other associated problems had occurred. In view of progressive loss of pigment, however, he decided on a recoloring procedure and lesions appeared a few weeks later. These were completely asymptomatic and extended progressively but remained confined to the tattooed skin. The patient did not have any drug allergies or report any medical or surgical history of interest. A biopsy was taken of one of the lesions, and large intracytoplasmatic inclusion bodies or "molluscum bodies" were observed inside the epidermal cells while a deposit of blackish pigment was apparent in the dermis. The laboratory tests included serology for HIV, HCV, and HBV, and were normal. Once diagnosis of molluscum contagiosum was confirmed, treatment included curettage of the lesions. No recurrence was reported.

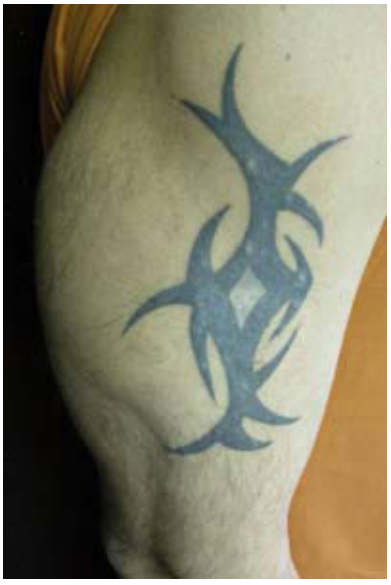

Figure 1. Black-dye tattoo on the right arm of the patient where several whitish papules can be seen confined to the pigmented area.

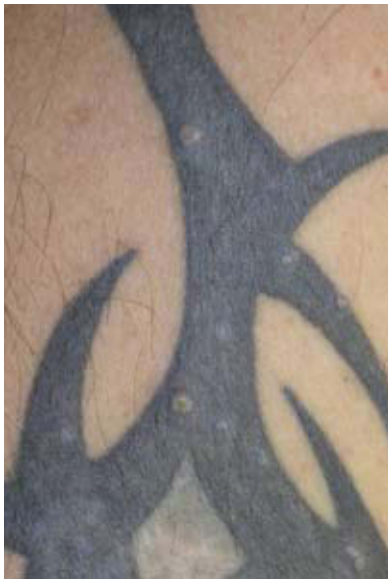

Figure 2. In greater detail, the lesions can be seen to be umbilicated with a central depression.

We found this case of interest because of the atypical presentation of molluscum contagiosum. Although this disease is very common, only 6 cases of molluscum contagiosum on tattoos have been reported in the literature. It is thought that the molluscum contagiosum virus might have been transmitted by the instruments that are used for tattooing or that the ink might have been contaminated with the virus. It has also been suggested that the black pigment might cause a localized weakening of cellular and humoral immunity[3-8] (Table).

In any case, it is clearly the Koebner phenomenon that was occurring, as molluscum contagiosum only appeared on the area of skin covered by the tattoo and onset occurred weeks after the tattoo had been done or manipulated. Such a phenomenon has also been reported at times with the appearance of lupus or sarcoid lesions on tattoos.[9]

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Conflicts of Interest

The authors declare no conflicts of interest.

Table. Characteristics of Cases of Molluscum Contagiosum on Tattoos Described Until Present

	Author/Year	*Age/Sex*	*Immunosuppression*	*Time Until Onset*	*Site*	*Color*	*Outcome*
1	Bergh R 1903[7]	NK	NK	NK	NK	NK	NK
2	Salmaso F et al 2001[4]	20/F	No	3 weeks	Left forearm	Black ink	No treatment
3	Foulds H 1982[5]	No	3 months	Left arm	Black inka/ red ink and copper pigment	Spontaneous resolution after 6 months	Desaparición espontánea en 6 meses
4	Pérez-Gala S et al 2006[3]	20/M	No	5 months	Left calf	Brown-graya/ black/others	NK
5	Kiang SH et al 2006[8]	NK	NK	Recent tattoo	NK	NK	NK
6	Kluger N et al 2007[6]	59/M	No	3 months	Chest	Monochromatic	No treatment
7	Pérez-Barrio S et al 2008[9]	36/M	No	3 weeks	Right arm	Black ink	Curettage without subsequent relapse

[a]Color of the tattoo on which the molluscum appeared
Abbreviations: F, female; M, male; NK, not known.

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Burning Mouth Syndrome and α-Lipoic Acid

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To the Editor:

Burning mouth syndrome (BMS) is a painful, chronic, idiopathic complaint characterized by a sensation of burning, pain, itching, or scalding of the oral mucosa in the absence of clinically evident lesions.[1] It is a common condition that usually affects postmenopausal women and that is often associated with anxiety, depression, or cancerophobia.[1] There are currently no effective treatments available and, among others, anticandida agents, drugs for ulcers, hormone replacement therapy, benzodiazepines, tricyclic antidepressants, selective serotonin uptake inhibitors, and psychotherapy are used.[2,3]

α-Lipoic acid (thioctic acid) is a potent antioxidant able to neutralize free radicals formed in the organism. It is a molecule that acts in aqueous and fatty media and that is active in both its reduced and oxidized state. In addition, it is able to regenerate other antioxidants such as glutathione, vitamin E, vitamin C, and coenzyme Q, and plays an important role in cell metabolism in that it acts as a cofactor in mitochondrial dehydrogenase-mediated reactions. Different clinical studies have demonstrated the neuroprotective effect and efficacy of this agent in the treatment of peripheral neuropathies caused by conduction disorders and neurotrophism.[4] At the recommended dose of 600 mg/d, no relevant adverse effects have been reported, even over long treatment periods. Its usefulness in BMS was proposed by Fermiano et al,[5-10] who suggested that the disorder behaves as a peripheral neuropathy influenced by stressful psychological events.

To test this hypothesis, we treated 10 patients who were suffering from BMS with α lipoic acid. A full medical history was taken, and the patients underwent a detailed examination of the oral mucosa; cultures for *Candida* species; and blood tests for vitamin B_{12}, iron profile, and antinuclear, anti-Ro, and anti-La antibodies to rule out other localized or systemic diseases that might cause similar symptoms. The severity of the BMS was assessed using a visual analogue scale (0, no pain/burning; 1, mild pain/burning; 2, moderate pain/burning; 3, severe pain/burning).

Oral treatment with α-lipoic acid (600 mg/d) and γ-linoleic acid (360 mg/d) was administered over 8 weeks. Therapeutic efficacy was assessed after 2 months using another visual analogue scale (0, no improvement; 1 slight improvement; 2, moderate improvement; 3, strong improvement).

All our patients were postmenopausal women and the mean age of the series was 63.7 years (range, 55-74 years). Items of note in the personal history included anxiety and depression (3 patients). The mean duration of BMS was 35.5 months (range, 2-96 months). The symptoms were severe in 4 patients, moderate in 5, and mild in 1. Among the prior medication, of note were topical measures (antiseptic mouthwashes, corticosteroids, antifungals) (10 patients), oral antifungals (1 patient), tricyclic antidepressants (3 patients), serotonin reuptake inhibitors (1 patient), and antipsychotics related to olanzapine (3 patients). One patient had a positive culture for *Candida* species and was treated with oral antifungals