included reactions noted in melanoma SNB reported an incidence of between 0.8% and 1.9%. The St George’s Hospital Melanoma database of sentinel node biopsies has been compiled since 1998 and currently has 1785 procedures recorded. No cases of anaphylaxis or other life threatening reactions have been observed. One confirmed adverse reaction to patent blue dye was noted in our series, a case of blue dermogaphia. This patient required no form of resuscitation and the procedure was completed without complication. St George’s Hospital Melanoma Unit therefore demonstrates an incidence of 0.056% of adverse reactions to patent blue dye, with no cases of life threatening reactions. This is significantly lower than the incidence reported by the ALMANAC trial.

The MHRA advice is based on evidence primarily from studies observing rates of reactions to patent blue dye in the setting of SNB for breast cancer. It could be hypothesized that different techniques of administering the dye such as peritumoural or periariolar used in breast cancer increase the risk of an adverse reaction to the dye when compared to the intradermal injections used in melanoma SNB. It may be that sub dermal injections increase systemic spread of the dye leading to more severe reactions. Similarly SNB for breast cancer is usually undertaken at the same time as the removal of the malignancy. As malignant tissues are often more vascular than normal tissue this may represent a route for greater systemic spread of the dye when compared to SNB for melanoma where the original lesion has usually been previously excised for diagnostic histology. This too may account for the higher rates of adverse reactions. Furthermore it is uncommon to use more than 1 ml of the dye in melanoma SNB. This is at least 50% less dye than the standardized volume of 2.0 ml used for breast cancer SNB in the ALMANAC study. This reduced volume may conceivably too affect rates of adverse reactions.

The risk of adverse reactions to the dye is not routinely mentioned during the consent process for SNB at St George’s Hospital. The St George’s Melanoma Unit has not experienced any life threatening reactions to patent blue dye. Our incidence of 0.056% of adverse reactions, being <1%, means that we would not routinely include adverse reactions to patent blue dye as part of our consent procedure. However individual units must reflect on their own experiences with patent blue dye and determine whether they should or should not routinely the risks of adverse reactions during consent.

Vigilance should always be encouraged however the St George’s Melanoma Unit’s experiences with patent blue dye would suggest it is safe having experienced a very low incidence of adverse reactions when used for melanoma sentinel node biopsy.

Ethical approval

Not required.

Funding

None.

Conflicts of interest

None declared.

References


S.A. Clarke
A. Molajo
B.W. Powell
St George’s Hospital, Department of Plastic Surgery, Blackshaw Road, Tooting, London SW17 0QT, UK
E-mail address: zchacc3@gmail.com

Crown Copyright © 2013 Published by Elsevier Ltd on behalf of British Association of Plastic, Reconstructive and Aesthetic Surgeons. All rights reserved.

http://dx.doi.org/10.1016/j.bjps.2013.03.036

Cutaneous lymphadenoma with unusual localization*

Dear Sir,

Cutaneous lymphadenoma is a rare epithelial neoplasm that arises mainly on the skin of the head and neck. It was first described in 1991 by Santa Cruz et al., and has been reported in the literature under various names e.g. benign lymhepithelial tumor of the skin and adamantinoid tri-choblastoma.. Histological findings have shown a florid mononuclear cell infiltration in the tumor nests and a detailed phenotypical analysis of T-cells showed that they mainly consisted of memory T-cells. As to whether cutaneous lymphadenoma is a benign or malignant skin tumor is under discussion by various authors but it has shown metastatic tendency.. We present a case of a cutaneous lymphadenoma with an unusual localization on the lower back in a 60-year-old man.

* Department to which the work should be attributed: Department of Plastic Surgery, Aalborg University Hospital, Sdr. Skovvej 3, 9000 Aalborg, Denmark.
Clinical findings

A 60-year old man, otherwise healthy, sought his general
physician because of a slow-growing element on the lower
back. The patient had had the small skin tumor for
approximately 10 years with no complaints except
cosmetic and an increase in size. The GP referred the pa-
tient with an presumed atheroma to a dermatologist for
surgical removal. The clinical findings were a solid tumor
measuring $22 \times 12$ mm, pale skin-colored and not well
defined from the adjacent skin. Though the tumor was
excised close to the borders, there was no remaining tumor
after excision.

Histopathological findings

Histologic examination revealed a well-circumscribed
unencapsulated intradermal lesion with multiple irregu-
larly shaped lobules, cords and interconnected strands
with a peripheral palisaded border of basaloid-like cells
and admixture of central mononuclear cells. No connec-
tion with the overlying epidermis on consecutive sections
was found. Areas of central keratinization were also
present. Immunohistochemical stainings revealed that
epithelial cells were positive for PanCK, EP4 (peripheral
border), but negative for EMA. Mononuclear cells within
the lobules and tumor stroma areas were positive for CD3,
CD4, CD5, TIA1. CD1a, CD68 and S-100 stain revealed
some positive cells within the lobules. From the above the
diagnosis of cutaneous lymphadenoma was made
(Figures 1 and 2).

Discussion

Cutaneous lymphadenoma is a very rare neoplasm, which
arises mainly on the skin of the head and neck. More than
40 cases of cutaneous lymphadenoma have been reported
and only few with localization other than head/neck. The
latest WHO classification of tumors considers it to be a
synonym of trichoblastoma (an adamantinoid tricho-
blastoma), but there is still debate regarding pathogen-
esis of this neoplasm. Histologically, cutaneous
lymphadenoma is composed of multiple rounded or
irregularly shaped lobules of basaloid cells with some
degree of peripheral palisading, with an intense infiltrate
of small mature lymphocytes within the lobules. Hist-
opathological differential diagnosis includes clear cell
basal cell carcinoma, clear cell variant of syringoma,
trichoepithelioma, lymphoepithelioma-like carcinoma of
the skin. However, the above-mentioned tumors do not
show such prominent lymphoid cell infiltrate within the
tumor lobules.

There is an ongoing discussion as to whether this tumor
is malignant or benign. Complete excision is therefore
recommended. Excision with Mohs surgery has earlier been
shown to be effective and safe. Two out of three patients
had the tumor removed in two stages, suggesting the
margins were not clinically well-defined, as was the case
with our patient, although microscopy showed no
remaining tumor. Hanlon et al. recommend Mohs as
being ideal for sparing as much of the healthy skin as
possible, while insuring complete removal with highest
cure rate and best cosmetic result, because the defect is
kept as small as possible, especially since the majority
of cutaneous lymphadenomas occur on the face. Mohs
micrographic surgery, though, is expensive and time-
consuming and we simply recommend re-excision if the
margins are not microscopically without tumor. After
complete excision there have been no cases of remission,
so this seems to be a safe and still a minimally invasive
method.

We present a case of cutaneous lymphadenoma with an
unusual localization on the lower back, treated with com-
plete excision, with no reported remission after 2 years.
Learning points

- Cutaneous lymphadenoma is a rare skin tumor of the neck and head, but it can also be seen on the legs or trunk.
- Re-excision if the margins are not microscopically free of tumor.
- Histologically, characterized by multiple rounded or irregularly shaped lobules of basaloid cells with some degree of peripheral palisading, with an intense infiltrate of small mature lymphocytes within the lobules.
- Clinically it can resemble an atheroma and histologically basal cell carcinoma, clear cell syringoma or lymphoepithelioma-like carcinoma.

Disclosures

Conflict of interest: None declared.
Funding: None.

References


J.E. Allen
K. Lundin
Department of Plastic Surgery, Aalborg University Hospital, Sdr. Skovvej 3, 9000 Aalborg, Denmark
E-mail address: julieellenn@hotmail.com

D. Erentaite
Department of Pathology, Aalborg University Hospital, Ladegårds gade 3, 9100 Aalborg, Denmark

A simple technique using the mini C-arm to guide depth gauge placement

Dear Sir,

Open plate-fixation of hand fractures relies upon efficient, accurate and safe insertion of the plate and screws. Screw length is ascertained using a depth gauge and, although depth gauge measurement may be certain in most cases, we have found that this is not true in some instances such as with more complex fracture patterns. This can result in several different measurements being made and subsequent incorrect screw length selection.

We present a simple technique that utilises the mini C-arm in conjunction with a depth gauge to assist accurate drill hole depth measurement in cases where doubt exists using the gauge alone.

This technique is used after guided hole drilling of the bone has been performed. Where there is measurement doubt using the depth gauge, we advocate that depth gauge insertion is accompanied by visual confirmation of accurate placement using the mini C-arm orientated perpendicular to the axis of the screw hole to obtain a screening image (Figure 1).

This uniquely described simple technique for drill hole depth measurement and screw choice in metacarpal fracture plate fixation prevents potentially unnecessary second screening after incorrect screw length placement with subsequent requirement for removal and reinsertion. This is due to direct visualisation of the depth gauge ‘lip’ as it has made contact with the deep volar cortex, and provides accurate measurement at the first attempt. It provides a visual reference image for subsequent drilled holes so that the likely depth may be anticipated, and thus rule out subsequent inaccurate drill hole measurements.

In cases with more complex fracture patterns the small ‘lip’ of the depth gauge may in fact miss the deeper volar

Figure 1  Fluoroscopic-guided depth gauge placement. The depth gauge lip can clearly be seen to be accurately placed.