Correspondence

Glomus Tumour with Intramedullary Bone Cyst: A Rare Presentation

Dear Editor,

A 30-year-old female presented to the dermatology clinic with complaints of severe pain on slight pressure on the left middle finger. The pain exaggerated on cold exposure. On local examination, there was bluish tinge seen under the nail plate at the terminal phalanx of the left middle finger and Love’s sign was elicited. The patient was advised magnetic resonance imaging (MRI), which on axial/T2W/PDSF/sagittal images of the terminal phalanx of the left middle finger at nail bed region showed focal midline hyperintensity measuring approximately 5 mm × 3 mm size [Figure 1] with mild cortical scalloping of underlying terminal phalanx. A small intramedullary bone cyst was also seen at metacarpal bone (distal level) of the left middle finger (incidental finding) [Figure 2]. Histopathology was consistent with glomus tumour [Figure 3]. Orthopaedic consultation for bone cyst of metacarpal bone of the left middle finger was done.

The digit to be operated was anaesthetized with proximal nerve block using the 2% lignocaine. Tourniquet was applied for having an avascular operating field. The nail plate was removed with the help of a Freer elevator. Glomus tumour was then visualised after removal of the

Figure 4:
Photomicrograph showing multiple blood vessels occupying almost the entire dermis (a) H and E, ×100. High power view showed proliferated capillaries with luminal differentiation and extravasated red blood cells (b) H and E, ×400

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The lesion was then excised and later cauterised, and pressure dressing was done. The patient was given antibiotics and anti-inflammatory drugs for one week. The patient was called for follow-up after 24 h to recheck for any bleeding, and on the 8th post-operative day, dressing was removed.

**DISCUSSION**

Glomus tumour is an uncommon hamartoma arising from glomus bodies which are arteriovenous shunts present mainly in digits and are composed of endothelium-lined vascular spaces (Sucquet-Hoyer canal) surrounded by glomus cells. It usually presents as bluish/red papules or nodules located in the dermis. Glomus tumours most commonly affect patients in the third to fifth decades of life, as were also seen in our study, although cases have been described in all age groups. The lesion is tender to slight touch and at times may be associated with severe paroxysmal pain in response to cold exposure and pressure. Mostly located in the nail beds and palm, but other cutaneous locations have also been reported. Cold sensitivity is the most accurate test (100%) aiding in diagnosis of glomus tumour after reviewing different clinical tests. MRI being a non-invasive technique has proven to be one of the most sensitive methods for diagnosis of glomus tumour and also delineating the tumour size and location preoperatively. Excision is the treatment of choice.

Simple bone cyst is benign cystic lesions seen commonly in skeletally immature persons. Males are twice more commonly affected than females. Common sites of occurrence are femur and humerus. Hand is a very rare site of occurrence. Treatment options for simple bone cyst include observation, curettage, bone grafting and intralesional steroid injection.

To the best of our knowledge, this is the first case report where subungual glomus tumour on the terminal digit of the left middle finger with intramedullary bone cyst of metacarpal head of the left middle finger is being reported.
Successful Management of Angiolymphoid Hyperplasia with Eosinophilia by Radiofrequency

Dear Editor,

Angiolymphoid hyperplasia with eosinophilia (ALHE) is a rare idiopathic condition, usually seen in adults and characterised by the presence of isolated or grouped papules, plaques or nodules in the skin of the head and neck region. Commonly, affected areas include periauricular region, forehead and scalp. [1] Various medical and surgical modalities are used for the treatment of this condition with variable success.

A 52-year-old male presented with complaints of extremely itchy dark-colored lesions over the left retroauricular area and concha for 8 years. The lesions started on the left retroauricular area and then, affected left ear over a period of 1 year. The patient gave a history of severe pruritus present throughout the day and sometimes also interfering with sleep and daily work. There was a history of profuse bleeding on manipulation. The patient did not give a history of preceding trauma or inflammatory dermatosis. He received treatment with topical steroids, antihistamines and intralesional steroids without improvement.

Cutaneous examination revealed multiple-grouped erythematous to hyperpigmented soft to firm papules and nodules coalescing to form plaques present over the left retroauricular area, concha and external auditory canal [Figure 1a and b]. Laboratory investigations of the patient did not reveal any abnormality except for mild peripheral eosinophilia. Skin biopsy taken from a hyperpigmented nodule on the left postauricular region revealed proliferation of small blood vessels, lined by enlarged endothelial cells with predominantly perivascular and interstitial infiltrate composed of lymphocytes and eosinophils [Figure 2a]. These distinctive endothelial cells had cobblestone appearance with uniform ovoid nuclei and intracytoplasmic vacuoles [Figure 2b and c]. Hence, a final diagnosis of ALHE was made.

The patient was treated with radiofrequency (RF) ablation under local anaesthesia. After a single session of RF, there was significant improvement with almost complete resolution of pruritus. Lesions healed completely in 3 weeks [Figure 3a and 3b] without any recurrence even at 2 years of follow-up.

Associated skin findings in ALHE include pain, pruritus and spontaneous bleeding after minor trauma. Patients usually present single lesions, but multiple nodules are seen in 20% of patients. Other features include regional lymphadenopathy and peripheral eosinophilia which is an inconstant feature. Histologically, it is characterised by proliferation of vascular channels with inflammatory infiltrate composed of lymphocytes and eosinophils. It can have a spontaneous remission, but symptomatic and disfiguring lesions may require treatment. Commonly used medical modalities include topical and intralesional corticosteroids. Other reported modalities include intralesional...