Abstract
A 34-year-old male came with complaints of multiple fleshy hard, nontender, nonitchy nodules, measuring 2 cm × 2 cm to 1 cm × 1.5 cm, present predominantly over the lower limbs. This condition started 5 years back as a single nodule over the thigh but gradually increased in number and size with time to involve both lower limbs. A differential diagnosis of cutaneous lymphoma and dermatofibroma was considered. He underwent a biopsy and immunohistochemistry for the same which were consistent with hemosiderotic histiocytoma and positive for vimentin. The patient was advised surgical excision for the same. The occurrence of multiple dermatofibromas although rare has been reported in a few case reports; however, the occurrence of multiple dermatofibromas of the hemosiderotic variant has not been documented yet.

Key Words: Hemosiderotic dermatofibroma, histiocytoma, vimentin

Introduction
A 34-year-old male presented with multiple tense brown to black nodules over the lower limbs measuring 2 cm × 2 cm to 1 cm × 1.5 cm, gradually increasing in size and number since the past 5 years. Lesions were nontender and nonitchy. On examination, the dimple sign was not present. A provisional diagnosis of dermatofibroma was made. Biopsy was done to rule out t- and b-cell lymphoma. Histopathology on hematoxylin and eosin section showed spindle cells arranged in whorls along with interlacing fascicles and storiform pattern with many cells containing hemosiderin pigment and surrounded by a few hyalinized blood vessels. Immunohistochemistry (ihc) was positive for vimentin. This confirmed the diagnosis of multiple hemosiderotic dermatofibromas.

Multiple dermatofibromas are rare; however, the occurrence of the multiple lesions of the hemosiderotic variant of dermatofibroma has not been reported yet.

Case Report
A 34-year-old male presented with multiple bluish black nodules, the largest measuring 2 cm × 2 cm and smallest about 1 cm × 1.5 cm.

Patient’s lesions initially started over the posterior aspect of the left thigh 5 years back as a pea-sized papule and gradually grew in size over time. The dark-colored nodules also increased in number at the time of presentation and were present predominantly over both the lower limbs. The lesions were nontender and nonitchy. There was no relevant past medical history and no history or clinical findings of immune-mediated diseases, insect bites, or concomitant infections. The patient was not on any specific treatment for the same.

On examination, the nodules on the lower limbs were discrete, dome-shaped, nonmobile, brown to black in color, margins being well defined, firm to hard in
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Consistency with the largest measuring 2 cm × 2 cm and smallest 1 cm × 1 cm [Figure 1].

A provisional diagnosis of multiple dermatofibromas was made. However, owing to the hemorrhagic appearance, we also wanted to rule out a B- or T-cell lymphoma.

The patient underwent a biopsy to confirm the diagnosis. The dermis showed a circumscribed neoplasm composed of plump spindle cells arranged in whorls, interlacing fascicles in storiform pattern [Figure 2]. The neoplastic cells exhibited mild nuclear polymorphism, oval to plump vesicular nucleus, some with prominent and moderate cytoplasm. Many cells contained hemosiderin pigment ratified by Perls stain [Figure 3]. The tumor edge infiltrated focally but no mitotic figures were noted. Also noted were a few hyalinized blood vessels.

IHC was positive for vimentin and negative for CD34, Melan A, HMB45, Ki-67, and S-100. The proliferative index was <1%. As the patient was negative for CD34, dermatofibrosarcoma protuberans was ruled out as well.

The diagnosis of multiple hemosiderotic histiocytomas was confirmed, and the patient was advised surgical excision for all his lesions.

Discussion

Multiple eruptive dermatofibromas (MEDFs) were first reported by Baraf and Shapiro[1] in 1970 and in this case report, they defined multiple as the presence of more than 15 dermatofibromas all over the body, the relevance of which is still in question. Dermatofibromas can result from something as trivial as an insect bite[2] or in association with an immune-mediated disease as part of an abortive process mediated by dermal dendritic cells.[3] There is also mention of a case report of MEDFs in association with HIV infection.[4]

These are persistent lesions and undergo very minimal change along the course of many years[5] and this is the reason why fully evolved dermatofibromas are rarely excised unless asked for by the patient.

There are few case reports of singular giant hemosiderotic dermatofibroma measuring larger than 5 cm[6] but never has there been reported the existence of multiple dermatofibromas of the hemosiderotic variant in a single case subject to the best of our knowledge.

Histopathologically, hemosiderotic variant of dermatofibroma present with numerous small vessels, extravasated erythrocytes, and intra- and extra-cellular hemosiderin deposits.[7]

Since dermatofibroma is a superficial form of benign fibrous histiocytoma, it is composed of a mixture of fibroblastic and histiocytic cells and on IHC, they have a profound positivity for vimentin and proliferating cell nuclear antigen[8] in addition to other macrophage markers such as HAM56 and CD68. In our case, the patient’s sample showed positivity for vimentin but was negative for CD34, Ki-67, HMB-45, and S-100. Factor XIIIa would be positive in dermatofibroma as against CD34 positivity in dermatofibrosarcoma protuberans.[9]

Dermoscopically, hemosiderotic and aneurysmal dermatofibromas usually show a multicomponent pattern with a central bluish or reddish homogenous area in combination with white structures and a peripheral delicate pigment network along with vascular structures.[10]
Treatment for MEDFs differs from person to person depending on the causality. In immune-mediated disease-related patients, a combination of steroids and a steroid-sparing agent[11] is usually found to be helpful. In other cases of MEDFs, the use of cryotherapy has been advocated over surgical excision to avoid cosmetically unacceptable wide atrophic scars.[12] In our case, the patient was given an option of surgical excision of the larger tumors; however, he preferred to wait and watch.

**Conclusion**

This case report was intended with the sole aim of enlightening us about the various morphological manifestations that can present in a patient with dermatofibroma, including the current variant mentioned in this article which closely mimicked a cutaneous lymphoma or a cutaneous lymphoid hyperplasia.

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Nil.

**Conflicts of interest**

There are no conflicts of interest.

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**What is new?**

Dermatofibromas have been known to occur in different clinical and histopathological variations. In our case report we document the presence of multiple dermatofibromas of the hemosiderotic histopathological variant, with an uncanny similarity to cutaneous lymphomas or a glomangioma.

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**Figure 3:** Perls stain showing hemosiderin deposits