treatment). Owing to her history of isotretinoin-associated PTC, an initial neurology consultation and monthly ophthalmology examinations were performed throughout the isotretinoin treatment period. She experienced dramatic acne improvement with only mild residual scarring. The only adverse effect was skin dryness, which resolved after isotretinoin therapy was completed.

Discussion | Pseudotumor cerebri is characterized by symptoms of increased intracranial pressure: headache, visual disturbances (blurry vision, diplopia), nausea and vomiting, and stiff neck. It is commonly idiopathic, primarily affecting women of childbearing age who are overweight. Less frequently, it can occur in association with other disease conditions (usually endocrinologic abnormalities such as polycystic ovarian syndrome).2

Despite many anecdotal reports of drug-associated PTC, there are 4 primary drug classes that are considered by experts to have a true association with PTC1,3: (1) tetracyclines, including doxycycline and minocycline; (2) oral retinoids; (3) recombinant growth hormone; and (4) corticosteroids (following withdrawal). Cross-reactivity between these drug classes in patients with drug-associated PTC has not been reported. Symptoms usually regress completely after discontinuation of the drug therapy.1,4

The pathophysiological mechanisms of drug-associated PTC are not fully understood. It has been postulated that tetracyclines may reduce cerebrospinal fluid outflow at the arachnoid villi, while oral retinoids (through excess retinols and reti-nol-binding protein) may be directly toxic to arachnoid villi function.5,6

We report safe use of isotretinoin in 3 patients with histories of drug-associated PTC. When acne warrants isotretinoin treatment, a patient history of PTC should not preclude its use if careful surveillance for PTC recurrence can be conducted. Baseline evaluation by ophthalmology and/or neurology services should be considered.

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Melanoma Gene Expression Markers for Surveillance of Epidermolysis Bullosa Nevi Malignant Transformation

The evaluation of malignant changes in epidermolysis bullosa (EB) nevi remains a challenge for clinicians; herein, we introduce the idea of employing melanoma gene expression markers to aid in thorough histopathologic examination of suspicious EB nevi lesions.

Report of a Case | A young girl with epidermolysis bullosa simplex (EBS) initially came under our care at age 4 years. Two years after her first presentation, she developed an irregular brown-black patch on her left lateral ankle. The lesion was a 3.6 × 3 cm triangular hyperpigmented, asymptomatic patch consisting of confluent mottled black and brown macules and several satellite lesions consistent with an EB nevus.

The patient returned at age 9 years and the parents noted slow but progressive growth of the hyperpigmented patch on her left ankle. On examination, several brown macules coalescing into a 5.5 × 5-cm patch with surrounding satellite lesions was seen on her lateral ankle (Figure 1A). Biopsy was performed of a representative area, showing a compound nevus with large nested melanocytes and bridging at the dermal-epidermal junction consistent with an atypical compound nevus (Figure 1B).

The patient was seen for follow-up every 6 months. The atypical nevus remained unchanged until age 12 years, when 2 discrete areas of regression were noted (Figure 2A). On dermoscopy, discontinuous and irregular homogenous blue, brown, and gray areas with gray-brown structureless areas and a negative pigment network were observed, suggestive of malignant transformation. No induration was palpated except at the previous biopsy site.

Repeated biopsy of the areas of clinical regression showed atypical nevus with areas of dermal fibrosis (Figure 2B). Gene expression testing for 23 melanoma genes was performed yielding a melanoma gene expression test (Myriad myPath; Myriad Genetics) score of −7.1, where scores from −16.7 to −2.1 are consistent with a benign nevus.
The score, in combination with the histopathologic findings, indicated that the changes seen on the clinical examination were benign. Therefore, we managed the lesion with conservative observation.

Discussion | Epidermolysis bullosa nevi in patients with EBS have been largely thought to be of low malignant potential despite their alarming mimicry of melanoma. However, with the recent report of a malignant transformation of a
malignant transformation. As EB nevi tend to be large, have a rapid, continuous growth phase, and occasionally regress over time, regular histopathologic evaluation of the nevi seems impractical, especially in pediatric patients who may not tolerate large, frequent biopsies. Even the histopathologic evaluation of EB nevi continues to be a challenge for the clinician, as blistering conditions can lead to pseudomelanomatous features that simulate melanomas.

With the use of melanoma gene expression markers, smaller biopsy samples can differentiate malignant transformations from benign lesions with high sensitivity and specificity. Employing such gene expression markers can be especially helpful in cases of atypia seen on histopathologic examination because the markers can aid in distinguishing pseudomelanomatous changes from true malignant transformations. With the use of melanoma markers in combination with traditional histopathologic analysis, clinicians may also identify subtler changes of a malignant gene expression signature that differentiates benign nevi from malignant melanoma.

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Recurrent Richter's Transformation Presenting With a Penile Ulcer

Richter’s transformation (RT) is a clinicopathologic entity characterized by the development of an aggressive lymphoid cancer in a patient with chronic lymphocytic leukemia (CLL). It classically presents with fever, weight loss, lymphadenopathy, and hepatosplenomegaly. We describe the first case to our knowledge of RT presenting with a penile ulcer.

Report of a Case | A 78-year-old man with CLL complicated by RT (transformation to diffuse large B-cell lymphoma [DLBCL]) in remission for the past 3 years was admitted for painful swelling and ulceration of the glans penis of 1 month's duration. Nine years earlier, on routine examination, he was found to have inguinal lymphadenopathy and an elevated white blood cell count. At that time, bone marrow aspiration and flow cytometry findings were consistent with CLL. Fluorescence in situ hybridization (FISH) analysis demonstrated trisomy 12 in 74.8% of cells, confirming CLL.

The patient was managed expectantly and doing well until he experienced fatigue, weight loss, and loss of appetite 4 years later. Computed tomography (CT) revealed extensive upper abdominal, mesenteric, retroperitoneal, and pelvic lymphadenopathy. Positive findings on positron emission tomography (PET) scan demonstrated a significantly elevated standardized uptake value of 16.9, maximum in the right inguinal region. Bone marrow biopsy and FISH analysis revealed trisomy 12 and a new translocation (14;18) in 89% of cells, consistent with transformation to DLBCL. Polymerase chain reaction analysis of the immunoglobulin (Ig) heavy chain gene demonstrated a clonal rearrangement. He required 6 cycles of rituximab-cyclophosphamide-doxorubicin-vincristine-prednisone (R-CHOP) chemotherapy followed by 6 cycles of bendamustine and rituximab treatment to achieve remission.

He was in his baseline state of health until 1 month prior to his present admission when he noticed asymptomatic “green-yellow welts” and swelling of the glans penis. In the following 4 days, the swelling became progressively painful and evolved to the size of an “orange.” In the subsequent 3 weeks, he was prescribed courses of topical antibiotics, a topical antifungal agent, hydrogen peroxide soaks, warm compresses, and cephalexin, all without improvement. The swelling and ulceration progressively worsened prompting admission for further evaluation.

At admission, he appeared healthy. However, the glans penis and corona were grossly edematous, with a 3.7 × 3.3-cm tender, firm ulcer on the ventral surface of the penis with overlying black eschar, adherent yellow crust, and granulation tissue (Figure 1). There was no urethral discharge. Routine blood test results were within normal limits. Findings of cultures, assays, and blood tests evaluating for a viral, bacterial, or fungal etiology were negative. A biopsy of the glans penis ulcer demonstrated a dermal infiltrate of atypical lymphocytes, which were CD20+, CD79a+, and CD5+, within the background of a reactive T-cell infiltrate (Figure 2). Polymerase chain reaction analysis revealed a clonal IgH gene rearrangement, matching that of the original transformation. A PET-CT scan demonstrated fludeoxyglucose (FDG)-avid abdominal and peripancreatic lymph nodes. Findings of a peripancreatic lymph node biopsy were consistent with relapsed RT. Empiric antimicrobial treatment was discontinued, and he was treated...