tumors on treatment with bevacizumab. Animal models had shown that the inhibition of the wound healing process at the level of the dermis can be dose-dependent and could be reversible when interrupting the administration of the drug.[4]

In our patient, as in the case of Murayama *et al*.,[5] we suspected that the impaired wound healing could be due to the neutralization of VEGF by bevacizumab. This was supported by the fact that improvement of the ulcer was observed when the treatment was stopped and worsened after the reintroduction of bevacizumab. After permanent withdrawal of bevacizumab lesions completely resolved.

In conclusion, we present the case of a 70-year-old woman treated with Bevacizumab for a metastatic ovarian cancer, who developed a refractory painful skin ulcer that healed completely after stopping this treatment. Dermatologists should be aware of the thrombotic events in the skin with antiangiogenic therapy. because they represent a significant adverse effect associated with their use.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Conflicts of interest

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Pigmented Bowen's disease on the finger mimicking malignant melanoma: A dermoscopic pitfall

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Sir,

Pigmented Bowen's disease, characterized by variable melanin deposition, constitutes 1.7%–5.5% of all Bowen's disease.[1] Involvement of finger is even rarer. We report a case of digital pigmented Bowen's disease clinically and dermoscopically resembling melanoma. This is a special case depicting both atypical pigment network and peripheral parallel ridge pattern on dermoscopy, which may lead to the misdiagnosis of malignant melanoma.

A 49-year-old man (Fitzpatrick skin phototype IV) presented with a dark-brown lesion on the lateral aspect of his left ring finger, progressively enlarging for last 1 year. Slight lesional pain developed since three months. Physical examination revealed a well-demarcated, asymmetric, slightly elevated, dark brown plaque with scaly surface, sized 18 mm. [Figure 1]. The patient denied any prior treatment. There was no history of exposure to arsenic, tar, or radiation. Family and past history were unremarkable.

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Lesional dermoscopy demonstrated atypical pigment network with peripheral parallel ridge pattern over an asymmetric dark brown background. We also observed dotted vessels in clustered arrangement, regression-like areas, and linear ulceration. [Figure 2]. Melanocytic parameters such as atypical pigment network and parallel ridge pattern mandated a skin biopsy to rule out malignant melanoma. Histopathological examination revealed full-thickness epidermal dysplasia along with atypical keratinocytes [Figure 3a]. No dermal invasion was noted. However, we observed melanin granules within tumor cells and dermal melanophages [Figures 3b and c]. We diagnosed the case as pigmented Bowen's disease after clinico-pathological correlation. We excised the plaque and no recurrence was detected at 11 months of follow-up.

Previously reported characteristic dermoscopic patterns of 52 cases of pigmented Bowen's disease included brown or grey dots and/or structureless brown zones, while "pigment network" was rare due to notable epidermal acanthosis along with loss of rete ridges.[1] However, we noted atypical pigment network without the classical brown or grey dots. The lines of atypical pigment network and parallel ridge pattern occurred due to melanin deposits within tumoral cells and irregular thickening of rete ridges. The holes of pigment network represented dermal papillary tips. Our dermoscopic findings may also be attributed to the atypical site of lesion. Our findings corroborate the hypothesis that neoplastic cells probably induce the proliferation and activation of melanocytes, similar to melanocytic lesions.

Peripheral parallel ridge pattern is the dermoscopic hallmark of acral melanoma, while diffuse light brown pigmentation in early stages become focally darker in advanced lesions.[2] BRAAFF checklist is a new dermoscopic algorithm to diagnose acral melanoma with 93.1% sensitivity and 86.7% specificity. The scoring system consists of six variables (blotches, ridge pattern, asymmetry of structures, asymmetry of colors, furrow pattern, and fibrillar pattern). We observed irregular blotches (1), ridge pattern (3), asymmetry of structures and colors (2) without furrow pattern and fibrillar pattern to obtain a BRAAFF score of 6, highly suggestive of acral melanoma [Table 1].[3]

Instead of parallel ridge pattern, parallel furrow pattern was reported in a case of palmar pigmented Bowen's disease.[4] Nakayama and colleagues also reported parallel furrow pattern in periungual disease without parallel ridge pattern (highly specific for diagnosing acral melanoma).[5]

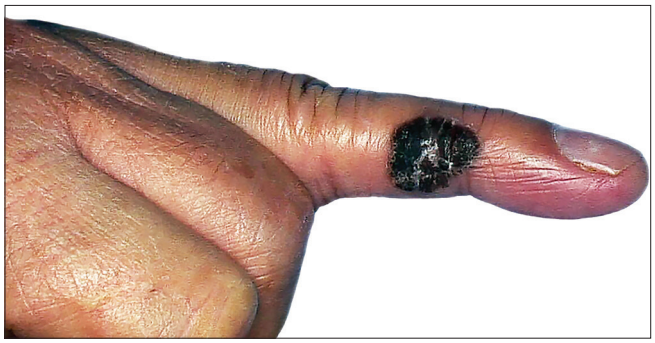

Figure 1: Elevated, asymmetric dark brown plaque on the left ring finger with scaly surface, measuring 18 mm × 14 mm in size

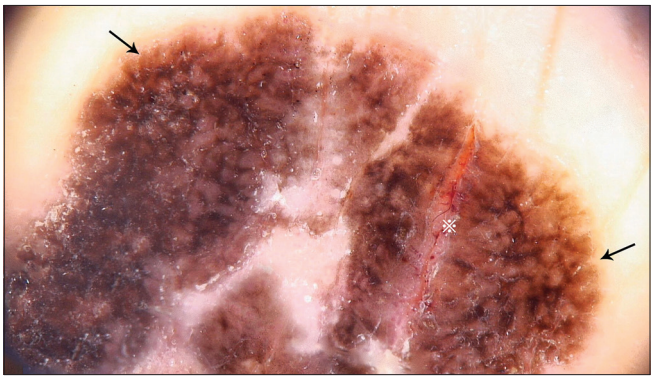

Figure 2a: Atypical pigment network (black arrows), linear ulceration (※)

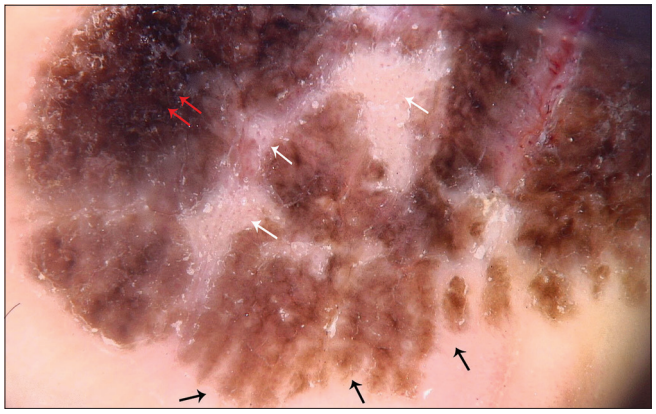

Figure 2b: Parallel ridge pattern (black arrows), dotted vessels on regression like areas (white arrows), and irregular blotch (red arrows). (non-polarized dermoscopy, ×20; Medicam 800, FotoFinder SystemsGmbh, Birbach, Germany)

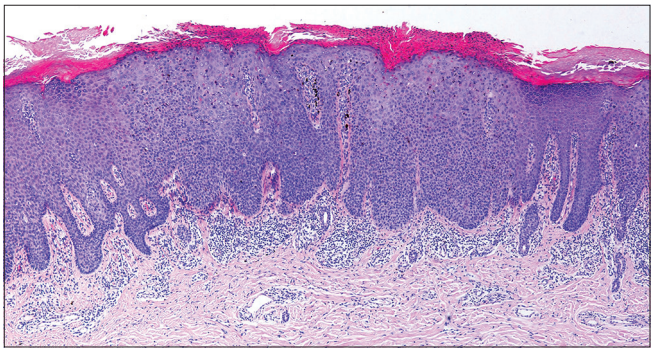

Figure 3a: Hyperkeratosis, parakeratosis, acanthosis and irregular elongation of rete ridges without atypical cells in the upper dermis were found (H and E, ×40)

Table 1: Dermoscopic characteristics of Pigmented Bowen's disease in our case compared with acral melanoma and common Pigmented Bowen's disease cases

Dermoscopic features	Pigmented Bowen's disease (our case)	Acral melanoma	Pigmented Bowen's disease (common cases)
Irregular blotch	+	+	-
Parallel ridge pattern	+	+	-
Asymmetry of structures	+	+	-
Asymmetry of colors	+	+	-
Atypical network	+	+	-
Regression structures	+	+	-
Fibrillar pattern	-	-	-
Parallel furrow pattern	-	-	+/-
Brown/grey dots	-	+/-	+
Structureless brown zones	-	+/-	+
Surface scale	+	-	+
Dotted vessels	+	-	+

+: present, -: absent

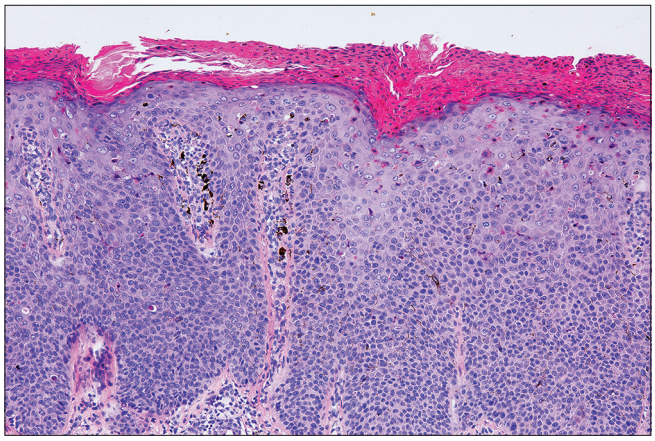

Figure 3b: Disorganized atypical keratinocytes throughout epidermis with densely distributed melanin granules (H and E, ×100)

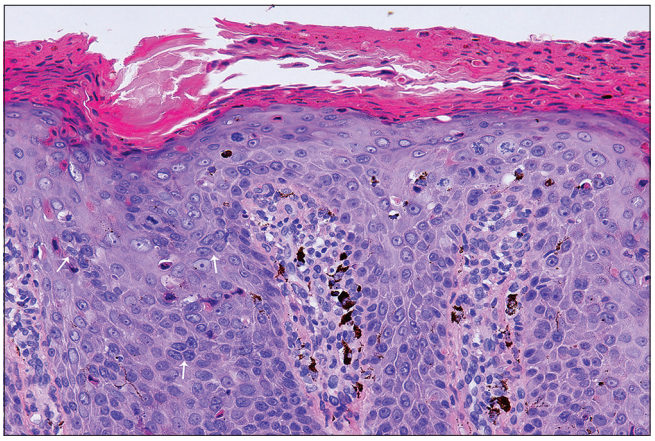

Figure 3c: Atypical mitotic figures (white arrows) and individual keratinized cells in the epidermis (H and E, ×400)

Besides, parallel brown to gray radial lines have been reported in digital pigmented Bowen's disease.[6] Furthermore, patchy, irregular reticular pigmentation was demonstrated in two cases, but both were less pigmented than our case.[7,8] Interestingly, we detected both distinct atypical pigment network and peripheral parallel ridge pattern in our patient.

We considered pigmented seborrheic keratosis, pigmented palmoplantar wart and acral melanocytic nevus as our differentials. A considerable number of pigmented Bowen's disease occur in association with seborrheic keratosis and may constitute a collision tumor.[1] Seborrheic keratosis presents with a waxy, scaly surface with characteristic "pasted on" look. The diagnosis of pigmented seborrheic keratosis can be challenging when its characteristic features are masked by heavy melanin deposition. However, cerebriform pattern, fingerprint pattern, comedo-like openings and milia-like cysts on dermoscopy are valuable markers for pigmented seborrheic keratosis. Occasionally such cases may also show "false" pigment network.[9] Pigmented palmoplantar wart clinically presents as a pigmented, rough, sharply-defined plaque with slightly keratotic surface caused by human papilloma virus infection. Underlying black dots representing thrombosed capillaries on paring are confirmatory. Dermoscopic examination usually reveals tiny dotted vessels on a brownish background, but parallel ridge pattern has been reported in plantar pigmented wart.[10] Most acquired acral melanocytic nevi present as round or spindle-shaped, well-circumscribed evenly pigmented brownish-black macules. However, our case presented with both asymmetric structures and colors. More than 75% of acral nevi exhibit one of these three major dermoscopic patterns: the parallel furrow, lattice-like and fibrillar patterns, neither was observed in our case.[11]

To conclude, we were unable to find any previous reports of pigmented Bowen's disease showing both distinct atypical pigment network and peripheral parallel ridge pattern, which are typical dermoscopic features of malignant melanocytic lesions. Although the dermoscopic evidence of surface scales and dotted vessels are indicative of the condition, we misdiagnosed it as melanoma, till histology confirmed our final diagnosis. Therefore, histopathological examination remains the gold standard for diagnosis, as demonstrated by our case. We also recommend the inclusion of pigmented

Bowen's disease as differential diagnosis of any pigmented lesion, along with malignant melanoma.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for his images and other clinical information to be reported in the journal. The patient understands that his name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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Dermoscopic features of cutaneous metastases from breast carcinoma: A report of three Indian patients

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Sir,

Dermoscopic features of cutaneous metastases from internal malignancies have been documented in only a few reports, predominantly in fair-skinned population.[1,2] Here, we describe the dermoscopic features of cutaneous metastases from breast carcinoma in three Indian patients.

Case 1: A 36-year-old female, with a previous history of left breast carcinoma treated with modified radical mastectomy and adjuvant radiotherapy one year back, presented with skin-coloured translucent to hyperpigmented papules and clear fluid-filled vesicles on the left mammary region and abdomen for the last three months. These skin lesions appeared

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