withheld and he was prescribed doxycycline 100 mg bid PO and topical metronidazole gel (0.75%) for local application twice daily. At follow-up after 8 weeks, there was almost complete clearance of the skin lesions [Figure 3] and improvement of his eye symptoms. Subsequently, the initial diagnosis of allergic conjunctivitis was revised by the ophthalmologists to ocular rosacea.

Granulomatous rosacea is a dermatosis characterized by small, discrete, yellowish brown papules and pustules distributed across the center of the face and eyelids. The eyelids, lower part of the forehead, nasolabial folds, cheeks and perioral areas are frequent sites of involvement. [3] Histopathological examination reveals perivascular and perifollicular noncaseating epithelioid granulomas. The prevalence of ocular involvement in rosacea varies between 3% to 58% in different reports.[3],[4] Various ophthalmological manifestations that can occur in rosacea include blepharitis, conjunctivitis, iritis, iridocyclitis, hypopyoniritis, and keratitis. Other unusual presentations of rosacea include rosacea fulminans, persistent edema of rosacea and rosacea conglobata. Rosacea fulminans is considered an extreme form of the disease. There may be a rapid onset without any prior history of rosacea. In persistent edema of rosacea, a hard, non-pitting edema is found on the forehead, glabella, upper eyelids, nose or cheeks. Rosacea conglobata is characterized by a chronic, progressive course with haemorrhagic nodular abscesses and indurated plaques.[5]

The temporal correlation between the application of the ophthalmic topical medications and appearance of symptoms led to an initial misdiagnosis of ACD in our patient. Absence of prior symptoms suggestive of rosacea also contributed to this.

This report highlights the importance of considering rosacea as a diagnostic possibility in cases of eyelid dermatitis.

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Glomus tumor with mucinous change

Sir,

Glomus tumors are relatively uncommon neoplasms arising from modified smooth muscle cells that are normally found in specialized arteriovenous shunts in acral sites, especially the fingertips. This distribution reflects their function because the arteriovenous anastomoses of these areas, also known as the Sucquet-Hoyer canals, are involved in temperature regulation. Sucquet-Hoyer canals are lined by endothelial cells, have several layers of glomus cells in their walls, and connect an afferent arteriole to an efferent venule.[1]

A 30-year-old housewife presented with the complaint of a painful right index finger since one year. She used to get intense pain with slight trauma on touch. The right index finger nail was removed, but there was little relief from the pain. On examination, a small 8-10 mm sized bluish tender swelling was noted just below the right index fingernail. An excision biopsy of this lesion revealed a neoplasm composed of a reticular network of tumor islands made up of monomorphous rounded cells (Figure 1). The cells had abundant pink or pale blue cytoplasm and monomorphous oval nuclei. Several dilated thick walled vascular channels were also seen within these tumor islands. The stroma had abundant

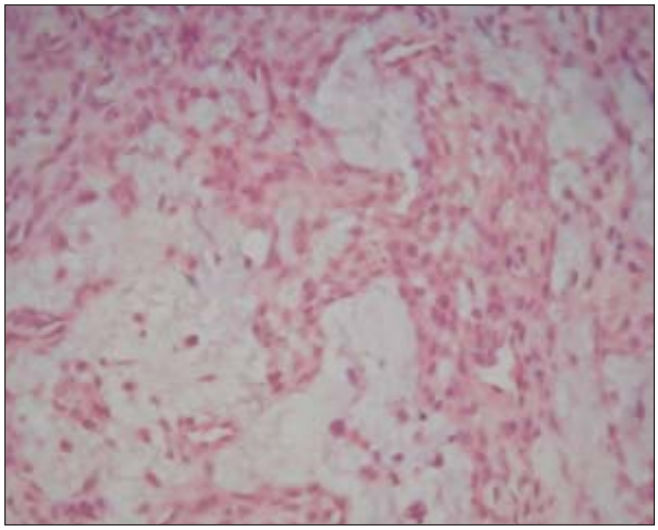

Figure 1: Abundant mucin within stroma and even within glomus cells

mucin, which appeared to be present within the neoplastic cells as well. Alcian blue stain confirmed the presence of abundant mucin within the stroma and the cells.

Mucin in glomangioma is rarely reported. Hisa et al reported four cases with mucinous degeneration, the extent of which correlated with the number of glomus cells.[2] Glomus tumors are thought to originate from their normal counterpart (e.g. the glomus cells); therefore they tend to occur most commonly in acral areas.[3]

The term glomus tumor is used to characterize two phenotypically different types of tumors: cutaneous glomangioma and paraganglioma. Both tumors can occur in a familial setting with an autosomal dominant pattern of inheritance.[5,6] However, they are of different histopathologic origin. Paragangliomas derive from the APUD cell system, whereas cutaneous glomangiomas originate from glomus bodies of the skin, which are important in the regulation of body temperature.[7]

An autosomal dominant pattern of inheritance has been described for glomus tumors of the paraganglioma type originating from the APUD cell system, the underlying genetic defect of which has been mapped to chromosome 11q23. In contrast, Blume-Peytavi et al showed that the genetic defect in disseminated cutaneous glomus tumors of the glomangioma type deriving from smooth muscle cells or pericytes is not linked to chromosome 11.[7] Thus, they suggested that the common term glomus tumor, used for both paragangliomas and glomangiomas in the current literature, is misleading and should be avoided because these tumors have different histologic derivations and genetic origins.[8]

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Recurrence of palmar hypertrophic chronic cutaneous LE after surgical excision

Sir,

Chronic cutaneous lupus erythematosus (CCLE) is the most common form of lupus erythematosus. It is a