

Statins have been widely used because of their effect on lowering blood cholesterol and for having a well-established role in preventing cardiovascular and cerebrovascular events. They also has an immunomodulatory effect on the negative regulation of MHCII expression. There is a shift from Th1 (T helper cells) to Th2, which leads to the increase of B cells, activating the excessive production of antibodies, besides exerting an inhibitory effect on natural killer cells (NKs), which are crucial for natural immunity against intracellular pathogens, thus compromising immune vigilance against viral infections and predisposing to tumor cell proliferation.⁵

Hence, it is possible to infer that statins predispose to *Polyomaviridae* infection and the consequent proliferation of MCC tumor cells, a phenomenon similar as that occurring with the immunocompromised.

Because of the rarity of the tumor, there is currently no standard consensus for treatment. One recommendation is broad surgical excision with free margins of 2 cm and adjuvant or isolated radiotherapy.⁵

We report a case of MCC in an immunocompetent patient with a diagnosis below the average age of those diagnosed with MCC, with no history of other skin cancers, and a chronic statin user, thus strengthening the correlation between MCC and statin use.

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Author's contributions

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Conflicts of interest

None declared.

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Millipede accident with unusual dermatological lesion^{☆,☆☆}

Dear Editor,

A 32-year-old male patient reported that, upon waking, he noticed injuries to his right leg, with local burning sensa-

tion and no other symptoms, and that he saw a millipede on the bed (Figs. 1–3). He went to the emergency room, where he was treated with antihistamines. Due to a lack of improvement, he sought a dermatologist. At the physical examination, the patient presented three spiral-shaped erythematous brownish spots, measuring approximately 3 cm each, located on the anterolateral surface of the right thigh. Clobetasol 0.05% ointment was prescribed, leading to an improvement of the burning sensation of the lesions.

Millipedes are animals of the phylum Arthropoda, the group with the largest number of invertebrate species. A member of the Diplopoda class, they have a cylindrical, segmented, rigid exoskeleton and two pairs of appendages or limbs (myriads) articulated in each segment, which move

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Figure 1 Spiral-shaped erythematous-brown spot on the right thigh.



Figure 2 Detail of the lesion.



Figure 3 Millipede after curling.

symmetrically and slowly, unlike centipedes (Chilopoda), which have only one pair of limbs per segment for support and thrust, giving them faster movement.¹

Millipedes are nocturnal animals that inhabit dark and humid places, and have two defense mechanisms: spiral curling (with the head in the center), providing greater resistance to the exoskeleton, and the discharge of an irritating secretion, which flows from glands on the lateral portion of each body segment when the animal is under threat or being crushed. The secretion can also be ejected from a distance.^{2,3}

The species related to human accidents in Brazil, *Rhinocricus padbergi* (family Rhinocricidae), is a member of the Spirobolida order, whose secretion is mainly composed of benzoquinone (2-methyl-1,4-benzoquinone), a highly irritating compound.²

These are mostly harmless animals; however, when defending themselves, they can excrete toxins that cause irritating and pigmenting chemical reactions in the skin.^{3,4} Accidents with children and adults usually occur when they are unconscious, lying on the floor, or during contact with clothes and shoes, especially during the rainy season, when millipedes invade urban areas and houses in search of shelter in a dark place.⁵ Almost immediately after contact, there is numbness and a burning sensation on the skin.⁴ The affected site becomes erythematous, with initially brownish-yellow pigmentation, darkening after 24h and turning reddish-brown to black, with a cyanotic appearance, a coloration that may persist for several months.³ Depending on the amount of secretion and exposure time, the pigmented lesion may dry out and peel in approximately seven days, or there may be blistering that, upon rupture, leaves the surface eroded.²

Most case reports describe pigmented lesions without a definite shape resulting from crushing the millipede. The present case is particularly interesting because the lesions reproduced the body shape of the millipede, in the defensive position, as an impression of the animal on the skin, mirroring the position of the secretory glands.

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Authors' contribution

Silmara Navarro Pennini: Conception and planning of the study; preparation and writing of the manuscript; intellectual participation in propaedeutic and/or therapeutic conduct of the studied case.

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Conflicts of interest

None declared.

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Primary diffuse cutaneous plasmacytoma: when a correct clinico-pathologic approach is mandatory for the patient's health ☆☆☆

Dear Editor,

A 76-year-old woman presented with multiple purplish plaques located on the arms (Fig. 1), deltoid region, elbows, wrist, mammary region, and legs. Lesions were painful at the touch without itching. Clinically, a diagnosis of eczema was suspected and a skin biopsy of the left arm was conducted.

Histological examination of hematoxylin & eosin-stained sections showed the presence of diffuse clusters of atypical oval-shaped cells with abundant cytoplasm, eccentric nuclei, “clock face” chromatin, and sometimes prominent nucleoli, infiltrating the medium and deep dermis (Fig. 2). Mitotic figures were seen. Neoplastic cells were morphologically similar to mature plasma cells, so a specific immunohistochemical panel was performed: they were diffusely positive for CD79a, CD138, CD56, MUM-1, and EMA, and totally negative for CD20. Immunohistochemical studies

for kappa and lambda light chains revealed a monoclonal expression of immunoglobulin kappa lights chains (Fig. 3).

To complete the diagnostic process, a bone marrow biopsy was performed; it was negative for multiple myeloma (MM) localization (less than 10% plasma cells; no clonal restriction). There were no Bence-Jones proteins in the urine. Hemogram and biochemical blood analysis revealed a normal value of hemoglobin and normal serum creatinine and calcium. Serum protein electrophoresis highlighted a lambda light chain spike.

Once the absence of other sites of disease was confirmed, a clinico-pathologic diagnosis of primary diffuse cutaneous plasmacytoma (PDCP) was rendered. Considering the extensive dissemination of the cutaneous involvement, the patient received systemic therapy. It consisted of bortezomib at the dosage of 1.3 mg/m² subcutaneously at day 1, 8, 15, and 22, melphalan given orally at the dosage of 14 mg at day 1, 2, 3, and 4, and dexamethasone at the dosage of 20 mg at day 1–2–8–9–15–16–22–23 (regimen). After nine cycles, fluorodeoxyglucose positron emission tomography-computed tomography showed complete disappearance of the skin lesions and absence of the lambda immunoglobulin G spike at the serum protein electrophoresis.

The patient completed therapy without adverse effects and, to date, after one year and eight months of follow-up, no recurrence of disease has been detected.

PDCP is a rare disease¹ that arises primarily in the skin, so it can be considered as a localized cutaneous extramedullary plasmacytoma (EMP) and should not be confused with secondary cutaneous plasmacytoma (SCP) in the context of MM.² According to a recent systematic review, only 68 cases of primary cutaneous plasmacytomas (PCPs) have been

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