

## CASE REPORT

### Perinasal angioleiomyoma in an elderly male

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#### ABSTRACT

Leiomyomas are rare benign skin tumors arising from the arrector pilorum muscle of hair follicle (cutaneous leiomyoma), from the media of blood vessels (angioleiomyoma), or from smooth muscle of the scrotum, labia majora or nipples (genital leiomyoma). Angioleiomyoma arises from the muscular coat of veins, and is seen mainly in middle age or later as a solitary nodule on lower limbs more commonly in females than males. We report here a patient with angioleiomyomas confined to the left nasolabial fold and ala nasi of recent onset in a 72-year old male, the oldest patient known so far to the best of our knowledge.

KEY WORDS: Angioleiomyoma, leiomyomas, elderly male

#### INTRODUCTION

Cutaneous leiomyoma are rare skin tumors. Three clinical types are recognized depending upon the muscle of origin; pilar leiomyoma (PLM), angioleiomyoma (ALM) and genital leiomyoma (GLM).<sup>1, 2, 3</sup> Pilar leiomyoma (leiomyoma cutis) originates in the arrector pili smooth muscle of the hair follicles and is the most common form. It can occur at any age from birth onwards, but appears usually in early adult life. It has been reported in identical twins, in siblings and in several generations of a family. The cases with a familial background have all had multiple tumors.<sup>4</sup> There is no sexual predilection. Genital leiomyoma (dartoic myoma) arises in the smooth muscle of the genitalia and mamillary muscles in the areola of the nipple.<sup>5,6</sup> It can occur at any age. The cutaneous variety is about six times more frequent than the genital type.<sup>7</sup> Angioleiomyoma arises from the smooth muscle of the veins, and is seen mainly in middle age or later as a solitary

nodule on a limb. Females are more commonly affected than males.<sup>8-10</sup> We report here multiple ALM on the face around the nose of a 72-year old healthy male.

#### CASE REPORT

A 72-year-old healthy male presented with 3, rapidly enlarging asymptomatic papules and one nodule over his left nasolabial fold and left ala nasi of recent onset. The lesions had appeared spontaneously 2 months back and rapidly enlarged in size. There was no h/o bleeding, pain, tenderness or itching in the lesions. He did not complain of any systemic complaints including respiratory symptoms. He had not received any treatment prior to presenting to us. His general physical and systemic examinations were normal. Cutaneous examination revealed one firm, non-tender, flesh colored, 1.0 cm size nodule with surface telangiectasia on his left nasolabial fold. Two flat reddish brown 0.5 cm, papules were

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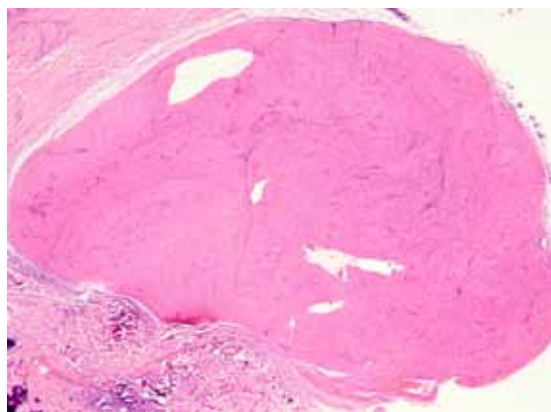
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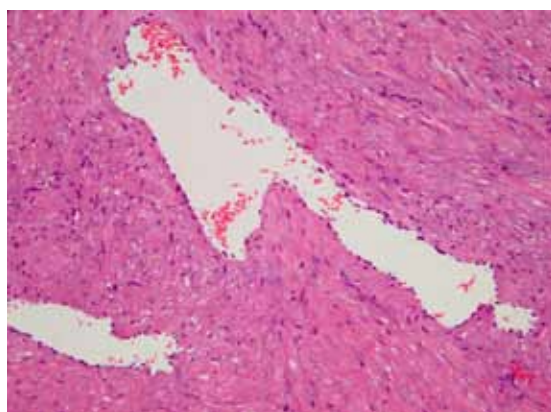
**Fig. 1** Skin colored and reddish brown papules and nodules over left nasolabial fold and ala nasi.

also present on the skin over adjacent left ala nasi (Fig. 1). Rest of the cutaneous examination was normal. His oral, genital and ocular mucosae were not involved. ENT examination did not reveal any lesion over nasal, oral cavity and larynx. Personal and family history was unremarkable. He had not travelled outside of Kuwait in past couple of years. Clinical differential diagnoses of atypical mollusca contagiosum, granuloma pyogenicum, angiofibromas and basal cell carcinoma were considered. Laboratory work up of complete blood counts, ESR, blood sugar, kidney, liver and thyroid function tests were all normal. Serology for syphilis (VDRL, TPHA), HIV and HHV 8 were negative. Chest x-ray and CT scan of nasal and paranasal sinuses, larynx and head were normal.

Histopathological examination of the excised nodule on the nasolabial fold revealed a well defined non-capsulated large dermal mass (Fig. 2). The mass was formed of intralacing bundles with fusiform nuclei. There were large vascular spaces lined by flat endothelial mononuclear cells and filled with erythrocytes (Fig. 3). Special stains for fungus, leishmania bodies and Gram's stain



**Fig. 2** Skin biopsy shows well localized, non-capsulated large dermal mass. There are large vascular spaces within the mass. The surrounding stroma shows condensed collagen fibers.



**Fig. 3** The mass is formed of interlacing bundles with fusiform cells and contains large vascular space with flat endothelial cells.

were negative. The histopathological findings were consistent with diagnosis of angioleiomyoma (ALM). The remaining two lesions were treated with PDL laser and there has been no recurrence even after 1 year of follow up.

## DISCUSSION

Classically ALM has been described as a solitary, flesh-coloured, rounded, subcutaneous or deep dermal tumour up to 4 cm diameter. It is more frequent on the lower limb than the upper and may appear on the trunk or face. Pain has been observed in about 50% of reported cases as compared to PLM where majority of the patients complain of pain on exposure to cold or touch. Lesions are

long-standing and present between the fourth and sixth decades of life, however a congenital case has been reported.<sup>11</sup> Pain may be triggered by changes in temperature, pregnancy or menses and the solitary painful lesion may be mistaken for a glomus tumour or an eccrine spiradenoma, and a history of contraction is helpful.

Pilar leiomyoma generally presents as a collection of pink, red or dusky brown, firm dermal nodules of varying size but usually less than 15 mm. The patient may complain of episodes of pain and tenderness. The pain can be provoked by touching or chilling the skin, or by emotional disturbance, and is often worse in winter. Some lesions contract and become paler when painful. The areas most commonly affected are the extremities. The trunk, head and neck can be affected. Multiple lesions may be regional and unilateral/zosteriform, or more than one region can be affected. Solitary lesions may occur, apart from the dartoid type. The gene that predisposes to multiple pilar leiomyomas has been mapped to chromosome 1q 42.3-q43.<sup>12,13</sup> It also predisposes to uterine leiomyomas (multiple cutaneous and uterine leiomyomatosis, MCUL) and to renal cancer.<sup>14</sup>

Genital leiomyoma usually presents as a solitary dermal nodule occurring most commonly in the scrotum, but also appearing on the penis, labia majora and nipple area. Scrotal tumours are often large. Pain is less frequent than with leiomyoma cutis. Surgical excision cures the solitary tumour. The severity of the pain may make the patient demand treatment, and extensive lesions require plastic surgery. Excision of an area containing multiple tumours is often followed by their appearance in the neighbourhood of the treated area. Calcium-channel blockers and gabapentin have been used to relieve pain.<sup>1,2</sup>

Our patient has unusual features such as late onset at the age of 72-years, absence of pain, contraction or tenderness on exposure to cold and touch. Clinically the lesion mimicked BCC because of shiny surface and telangiectasia.

## CONCLUSION

Angioleiomyoma a rare tumor of smooth muscles of blood vessels can arise at late age and at any site. This is the first case of AL occurring over the face.

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