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Sir,

A case of cutaneous collision tumour: the importance of photographic documentation and large incisional biopsy

An 87-year-old lady presented with a 1-year history of a left medial canthal lesion. There had been no recent change in its colour or size, nor associated bleeding or pruritis. She gave no history of previous skin lesions or excessive sun exposure. The lesion appeared as a firm pearly nodule $7 \times 8\,mm^2$ (Figure 1a) with small telangiectatic vessels on its surface and no associated pigmentation. It did not involve the punctum or canaliculi. This clinical appearance was suggestive of a basal cell carcinoma.

The lesion was photographed and an incision biopsy performed. Histopathological examination identified a cylindroma (Figure 1b). However, the preincisional clinical appearance of the lesion, confirmed by review of the photograph (Figure 1a), cast doubt over the biopsy result (postincisional Figure 1c appearance). A second incisional biopsy was thus performed, which revealed two separate pathologies (Figure 1d), a cylindroma and adjacent nodular basal cell carcinoma. The patient underwent Mohs' micrographic surgery and the defect reconstructed by direct closure.

Comment

Contiguous or 'collision' tumours are an unusual entity. A retrospective study of 40 000 cutaneous biopsies found only 69 such examples.[1] The association of an adnexal tumour and a second neoplasm was found in only four patients, but none were contiguous with a BCC. In fact, this is a very rare association.

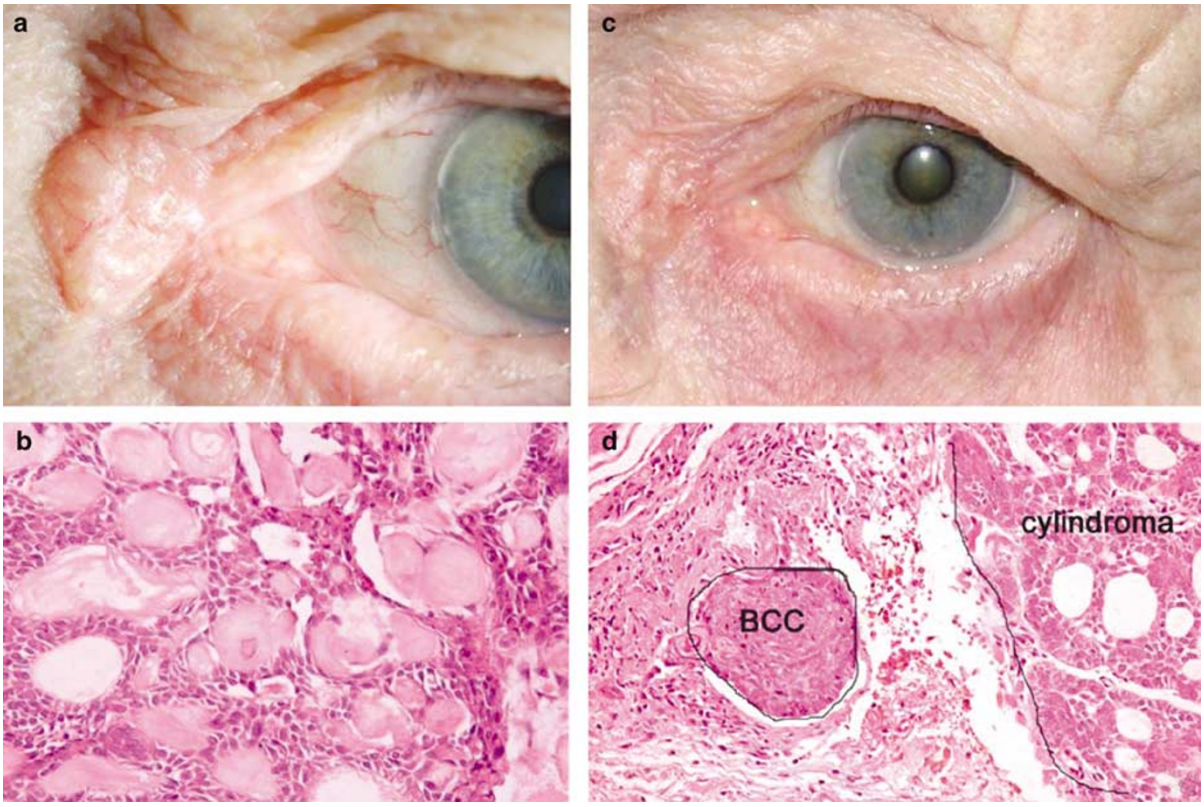

Figure 1 (a) Preincisional photograph showing a lesion at the left medial canthus. (b) Haematoxylin and eosin stain of the first biopsy specimen. High power (× 200). The lesion is composed of lobules of cells with large vesicular nuclei surrounded by thick eosinophilic material. There is widespread ductal differentiation. The appearances are consistent with those of a cylindroma. (c) Postincisional photograph of the lesion illustrating the change in the appearance of the lesion following the diagnostic biopsy. (d) Haematoxylin and eosin stain of the second biopsy specimen. High power (× 200). Two different tumour types are seen. A focus of cylindroma is seen (right) juxtaposed with a focus of basal cell carcinoma (left). In this sample, the two lesions are intimately associated but appear separate.

Certain associations such as between cylindromas and apocrine cystadenoma are expected, as they are sweat gland proliferations. Similarly, basal cell and squamous cell carcinomas are malignant proliferations of keratinocytes and have similar histogenesis. However, most collision tumours occur by chance, and are not derived from similar cell lines nor share pathogenic mechanisms.

The coexistence of two or more neoplasms in a single cutaneous specimen is unusual and can be diagnostically misleading if only one of the two is discovered. Biopsy reports must always be questioned in the light of the clinical history and examination. Unless histopathological diagnoses are considered alongside the clinical appearance of the original lesion, which may be altered by surgery, the anomaly may not be questioned.

It is essential therefore that new lesions be photographically documented prior to any intervention. This will aid in the patient's future management particularly in situations where the patient is reviewed by a different clinician at subsequent visits. This objective tool is especially important in cases where the clinical appearance does not correlate well with histological findings. Performing a large incisional biopsy will also maximize the chance of identifying multiple lesions.

Reference

1 Boyd AS, Rapini RP. Cutaneous collision tumors. An analysis of 69 cases and review of the literature. *Am J Dermatopathol* 1994; **16**(3): 253–257.

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Sir,

Serratia marcescens endophthalmitis secondary to pneumonia

A 56-year-old female was admitted to ITU with postoperative pneumonia secondary to *Serratia marcescens* treated with Imipenem 750 mg b.i.d. i.v. She underwent bowel resection for Crohn's disease 1 week prior to her pneumonia. A month later, she arrested and became comatosed despite resuscitation. She deteriorated, developing renal failure requiring haemofiltration. *S. marcescens* was grown from sputum and blood cultures and Teicoplanin 400 mg b.i.d. i.v. was started. After 24 h, she developed an acute right red eye.

On examination, there was an afferent pupillary defect, corneal oedema, and hypopyon. There was no fundal view (Figure 1). Examination of her left eye was unremarkable. A diagnosis of endogenous endophthalmitis was suspected and a vitreous tap performed with Ceftazidime 2.25 mg, Vancomycin 1 mg, and Amphotericin 5 μg given intravitreally. In addition, she was given hourly G Cefuroxime 5% and G Gentamicin 1.5%. *S. marcescens* sensitive to Ceftazidime was isolated from her vitreous and a repeated intravitreal injection of Ceftazidime and Vancomycin were given 72 h later. There was little ocular or systemic improvement and despite aggressive treatment she eventually died of multiple organ failure. An autopsy was declined.

Endogenous endophthalmitis (EE) accounts for 10% of all endophthalmitis.[1] Fungi are the most common causal pathogen[2] followed by bacteria.[1,3] Risk factors include systemic immunosuppression, sepsis, major surgery, indwelling catheters, and prolonged antibiotic therapy.[2] The overall prognosis is poor with useful vision preserved in only 40%, 6 and 7–15% patients die from septicaemia.[4,5]

Identifying the underlying cause is paramount. Conjunctival swabs poorly reflect intrinsic eye infection and vitreous tap/biopsy[6] should be performed and intravitreal antibiotics administered.

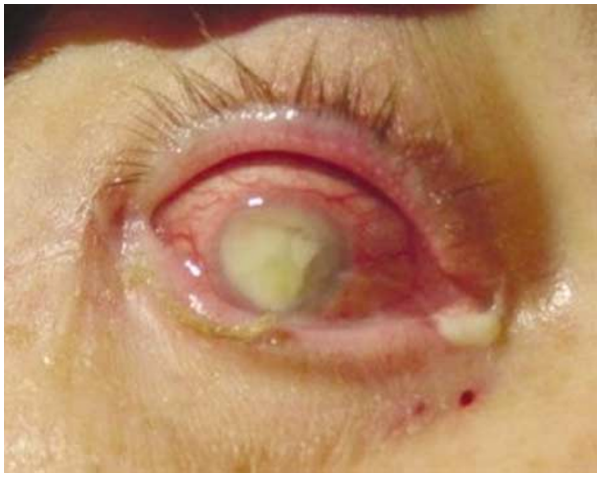

Figure 1 Right eye of patient showing scleral injection, corneal oedema, and hypopyon.