Two weeks previously, she was restless and irritable and had bizarre behaviour. She claimed that she was a special kind of human. Her symptoms increased in the last two days and her family reported that she had totally changed and became religious.

In her mental examination, she was irritable. There were spontaneous increases in her attention. She had paranoid and grandiose delusions and her insight was poor.

When her medical history was examined, it was noted that she had visited a dermatologist two months ago with severe acne complaints. Roaccutane was prescribed to her. During her treatment, her skin complaints had disappeared. Triiodothyronine (T3), thyroxine (T4), thyroid-stimulating hormone, liver function tests and blood count results were normal.

She was diagnosed with manic episode, and haloperidol (20 mg/day), biperidin (4 mg/day) and olanzapine (20 mg/day) were prescribed to her. Her Roaccutane medication was stopped. No pathologic findings were observed in her magnetic resonance imaging (MRI) and electroencephalography (EEG) results.

She recovered from the acute episode in about 15 days. Haloperidol was reduced and later discontinued. Valproate (1000 mg/day) mercury treatment was maintained with olanzapine (10 mg/day).

According to her Rorschach test results, she had a neurotic structuring, feelings of inadequacy and she was depressive, anxious and narcissistic. She used to cope with difficulties with hypomanic defence mechanisms. No family history of psychiatric illness was determined. Approximately one month later, she asked us to restart Roaccutane medication. Because it might lead to depression, we explained that restarting Roaccutane medication was not a good idea. The patient was closely monitored and controlled while reducing and discontinuing olanzapine. She was able to continue her education. Neither manic nor depressive episodes recurred during two years follow-up, although her grandmother died during the treatment process. After two years, valproate was reduced and later discontinued. During this period, she finished her study and began to work in a corporation. We visited her every three months. Finally, she went to live in another country after not using any drug, and psychiatric control for 1.5 years.

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Dangerous Ulcerative Lesion in the Inguinal Area?

The Editor,

Sir,

Squamous cell carcinoma (SCC) is among the most frequent skin cancers, with sunlight being one of its most recognized aetiopathogenic factors, although it is well recognized that it can also occur in non-sun exposed sites, most certainly having other causative factors. Some authors believe that the large diversity of histological variants and locations account for the different behaviour and prognosis within this heterogeneous group of neoplasms (1). One important fact is that they may vary from lesions with a low metastatic potential to others that possess a high potential for invasion and metastases (2−4).

The authors present the case of a 68-year old patient who attended the outpatient clinic for a lesion on the left inguinal fold that had been present for two years. He had no significant previous medical history or chronic medication. He reported no excessive alcohol intake or smoking habits and denied risky sexual behaviour. On observation, a large ulcerated lesion of 2.6 × 1.9 cm was seen, with a slightly raised edge, and an area of perilesional erythema and brownish pigmentation. There was no palpable inguinal lymphadenopathy (Fig. 1).

Histological examination of the excision specimen revealed features consistent with a non-keratinizing poorly differentiated SCC (Fig. 2). The tumour infiltrated the dermis to a thickness between 2 and 6 mm (stage pT2c). Ultrasound revealed a solitary enlarged lymph node measuring 20 x 6 x 6 mm above the right inguinal ligament. The patient was submitted to excision of the lesion with 1 cm margin and adjuvant radiotherapy with a dose of 25 x 2 Gy directed to the inguinal nodes.

Four months later, he presented with enlarged lymph nodes in the left inguinal area, with involvement of intrapelvic nodes on computed tomography (CT), and was subsequently treated with lymph node dissection (three lymph nodes positive for SCC with extracapsular spread, upgrading patient's stage to $pT_2N_2M_X$), further radiotherapy and adjuvant chemotherapy with methotrexate. About one

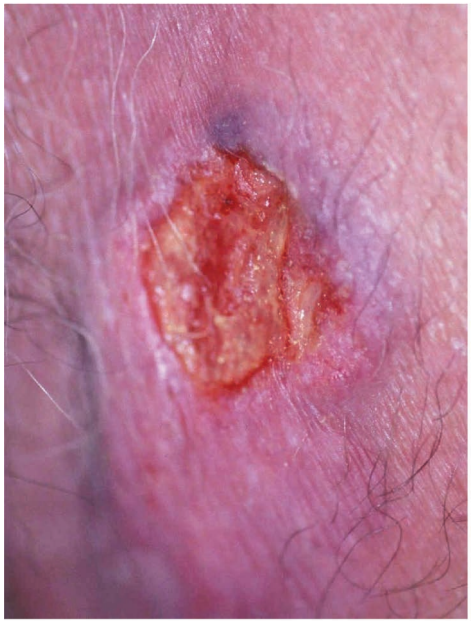

Fig. 1: Squamous cell carcinoma with a low degree of differentiation (×40).

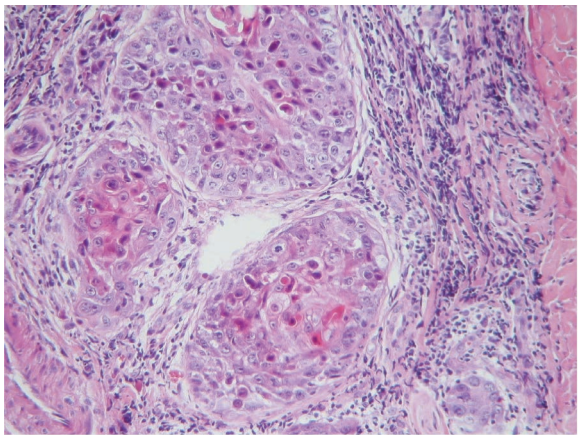

Fig. 2: Squamous cell carcinoma – sheets of large cells with marked pleomorphism and hyperchromatic nuclei with presence of incomplete keratinization (×200).

and a half month later, there was extensive local and iliac tumour recurrence, complicated by infection, and the patient was submitted to palliative surgical removal of the mass. The patient died due to pulmonary embolism subsequent to deep vein thrombosis shortly after.

This case illustrates the fact that adequate tumour characterization and staging are of paramount importance in order to predict prognosis and select the most appropriate therapeutical approach (5). Poorly differentiated tumours probably carry a higher risk of early lymph node involvement (6). Together with an endophytic growth in the absence of ulceration, recurrence after local treatment and poor response to systemic treatment, these features should always raise concern to the dermatologist (7). Tumour, node, metastasis (TNM) staging seems particularly useful when approaching these patients, since it appears to correlate well with survival (6−8).

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