dermatosis of the scalp. Biopsy revealed granulation tissue. The patient underwent PDT and prednisone treatment with improvement. Additional biopsies revealed AKs. His condition improved with 2 PDT sessions but never fully cleared. During the PDT sessions, the patient reported intense unilateral headaches without visual changes. The headaches were intermittent and not apparently related to the treatments. He was referred for a temporal artery biopsy and rebiopsy of the remaining lesion on the scalp. The temporal artery biopsy was negative. The lesion that remained was a large nodule on the vertex scalp, and biopsy revealed AFX.

Immunohistochemical marker studies for S-100 and cytokeratin were negative. Invasion into subcutaneous fat was encountered (Figure 2A). Highly atypical spindle cells and mitoses were present (Figure 2B). Neoplastic cells were noted adjacent to nerve (Figure 2C). Excision of the lesion was curative, and his symptoms of pain and erosive pustular dermatosis resolved weeks thereafter (Figure 1B). The area of erosive pustular dermatosis was not excised, but symptoms resolved weeks following excision of the AFX.

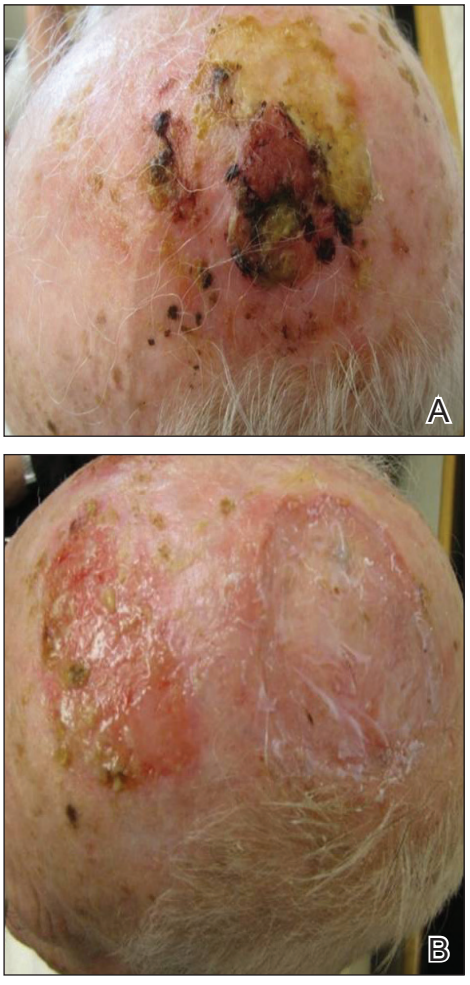

FIGURE 1. Atypical fibroxanthoma arising within erosive pustular dermatosis with evidence of erosion with crusting and granulation tissue before (A) and after excision of the lesion (B).

Comment

Our case of AFX is unique due to the patient's atypical presentation of severe pain. Because AFX usually presents asymptomatically, pain is an uncommon symptom. Based on the histologic findings in our case, we suspected that neural involvement of the tumor most likely explained the intense pain that our patient experienced.

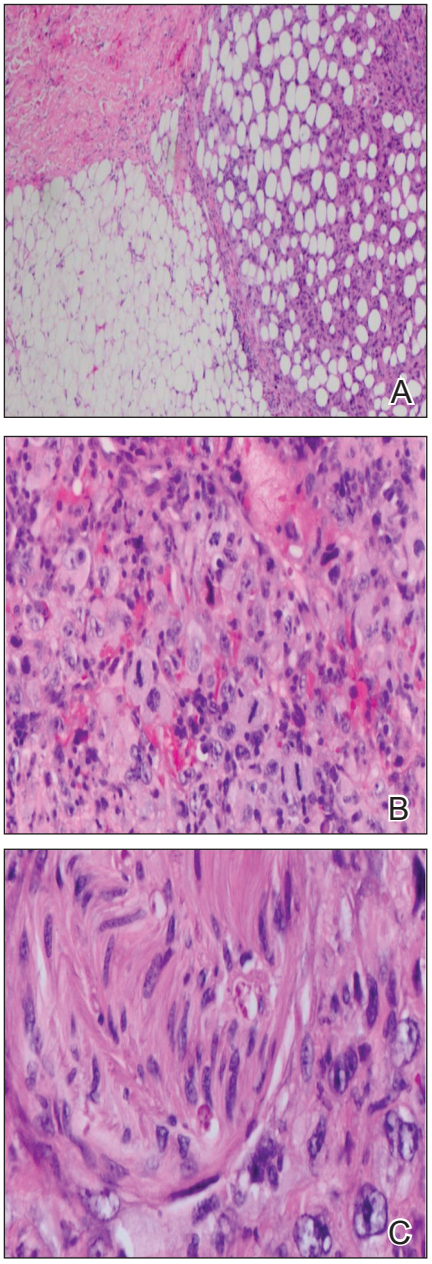

FIGURE 2. Atypical fibroxanthoma immunohistochemistry showed invasion into subcutaneous fat (A), highly atypical spindle cell neoplasm with mitoses (B), and neoplastic cells adjacent to neural tissue (C) (all H&E; original magnifications ×40, ×200, and ×400, respectively).