



Figure 4.—Six months after the beginning of the therapy.

PIH, secondary to ferrous sulphate irritant contact dermatitis. PIH is an acquired partial or total loss of skin pigmentation occurring after cutaneous inflammation. Ferrous sulphate, used diluted in water in gardening as refreshing and anti moss, if used as such, is an irritant.⁴ The vitiligo-like picture is more frequently found in cases of chemical leukoderma in which, however, the depigmentation appears after repeated contacts with melanocytotoxic substances.² PIH, on the other hand, usually appears after a single exposure to a pathogenic noxa and is, in most cases, preceded by an inflammatory pattern.¹ Iron is an extracellular stress that can activate a multitude of intracellular second messenger systems inducing regulated cell death, such as NADPH oxidase that lead to the increase of reactive oxygen species.⁵ Moreover, melanin production in response to cutaneous inflammation or trauma is variable.¹ Indeed, the susceptibility to damage of melanocytes is genetically determined and some people are more likely to develop hypopigmentation. Through the release of multiple mediators of melanogenesis (*e.g.* growth factors, cytokines), cutaneous inflammation may cause aberration of melanogenesis and severe inflammation may lead to loss of melanocytes or even melanocyte death, and thus to pigmentary changes.¹ The histology of PIH is non-specific: reduced number of epidermal melanocytes and variable superficial infiltration of lymphohistiocytes, melanophages in the superficial dermis.¹ However, it might be possible that the skin inflammation can induce a true vitiligo through the Koebner phenomenon: this possibility, in our patient, seems to be excluded due to the negativity of the anamnesis and the spontaneous and relatively rapid repigmentation.² It is necessary to stress the patient with the anamnesis for identifying the cause, that sometimes is not so evident because a lot of chemicals can be irritant to the skin if misused.

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Basal cell carcinoma under the rainbow

Dermoscopy of basal cell carcinoma (BCC) was first described some years ago. Menzies *et al.*¹ proposed some simple dermoscopic criteria to diagnose the BCC: the absence of a pigmented network, and the presence of at least one of six positive morphologic features. These features include ulceration not associated with a recent history of trauma, multiple blue gray globules, leaf-like areas, large blue-gray ovoid nest, spoke wheel areas and arborizing vessels. During the last decade additional criteria have been identified: whitish veil, brown globules, scar-like depigmentation, pepper-like gray dots, milia-like cysts, comedo-like openings, blue-gray areas and black-brown dots. Rainbow pattern (RP), typically associated to Kaposi's Sarcoma, could be found in some others malignant skin neoplasm, but is rarely reported in BCC.^{2,3} We report a case of RP

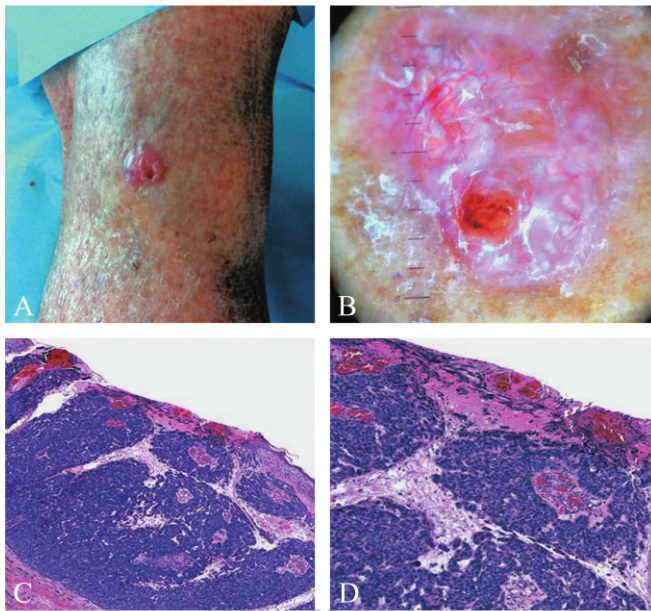


Figure 1.—A) Right leg with nodular lesion and small bleeding; B) dermoscopy of BCC (HEINE DELTA® 20 T Plus). Rainbow pattern with scales, arborizing vessels, clear cut ulceration and white shiny streaks; C) histologic examination (H&E stain, 10×) of infiltrative BCC with cystic adenoid appearance, ulcerated, infiltrating the deep dermis with no evidence of perineural-vascular invasion; D) histologic examination (H&E stain, 20×) to evidence the increased vascularization.

under polarized dermoscopy in BCC.

A 74-year-old man with a nodular lesion on the right leg came to our attention. He reported the appearance of the lesion about a year before. He described the lesion as painless, not itchy. At the physical examination the lesion appeared nodular (25×11 mm) with small bleeding (Figure 1A). Under polarized dermoscopy (HEINE DELTA® 20 T Plus) it was observed a RP with scales, arborizing vessels, ulcerations and white shiny streaks (Figure 1B). The patient underwent excisional biopsy. Histologic examination revealed an infiltrative BCC with cystic adenoid appearance, ulcerated, infiltrating the deep dermis with no evidence of perineural-vascular invasion. This lesion showed an increased vascularization located between the islands of basaloid cells (Figure 1C, D).

RP is a phenomenon related to the different states of polarization of the light interacting with the deep component of the lesion.⁴ Increased vascularization likely justifies the dermoscopic pattern of this case of BCC. Other cases of RP have been observed in melanoma, stasis dermatitis, lichen planus,⁴ Merkel cell carcinoma,⁵ and atypical fibroxanthoma.⁶ RP is a typical dermoscopic feature firstly described in Kaposi's Sarcoma,⁷ however we believe it can be included among the additional diagnostic criteria for BCC, in particular in its infiltrative form.

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Prolonged survival of a patient with brain melanoma metastasis treated with BRAF and MEK inhibitors combination therapy

Patients with advanced melanoma have a poor prognosis, with 1-year survival rates as low as 33% and a median overall survival (OS) of approximately 9 months.¹ Until recently, systemic treatments for metastatic melanoma (MM) were largely ineffective. Following the discovery of *BRAF* mutations in melanoma,² there has been rapid development of selective BRAF inhibitors, leading to a major shift in the treating of patients with BRAF-mutated mel-