Atypical Fibroxanthoma of the Auricle

Fibroxantoma atípico en el pabellón auricular

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A 71-year-old male consulted for an asymptomatic, progressively growing nodule in the earlobe. It was purplish-red and firm, not pedunculated or ulcerated (Fig. 1).

The lesion was removed via wedge resection, presenting a symmetrical tumour formation, well circumscribed in dermis. It was composed of a proliferation of fusiform cells, occasionally xanthomized, with marked nuclear pleomorphism, prominent nucleoli and atypical mitoses (Fig. 2), together with multinucleated giant cells.

Immunohistochemistry revealed positivity for vimentin (Fig. 3A), actin, CD68, CD99 and CD10, while results for S100, HMB45, CD34, desmin, caldesmon and cytokeratins AE1/AE3 and 20 (Fig. 3B) were negative, confirming that it was an atypical fibroxanthoma. This entity constitutes a diagnosis by exclusion, given that the image of fusocellular proliferation described is shared by other, more aggressive tumours such as desmoplastic melanoma, sarcomatoid squamous cell carcinoma and other pleomorphic sarcomas.

Rarely producing metastasis, it is classified as a sarcoma of intermediate level of malignancy within the
fibrohistiocytic tumours. It presents as a single nodule, reddish or skin-coloured, odourless and rapidly growing, occasionally ulcerated or pigmented. It occurs more frequently in males and usually appears in photo-exposed areas at advanced ages. Its treatment is surgical; follow-up of at least 2 years is recommended, given that 5%–10% of them recur locally. Some authors even advocate Mohs surgery.

Consequently, although the most frequent malignant tumour in the earlobe is squamous cell carcinoma, when a nodule in this location is involved, other diagnostic possibilities should be considered as well.

Conflict of Interest

The authors declare no conflict of interest.