

similar to a collection of flowers (Fig.2). They were marked by intense glucagon immunostaining. The findings were consistent with the recently recognized entity GCA. Mutation analysis of the tissue samples for MEN1, VHL, and p27 genes was unsuccessful because of the poor preservation of DNA within the pancreatic tissue.¹

GCA and GCA-like entities have rarely been reported.²⁻⁴ In GCA there is no solitary pancreatic tumor but rather diffuse enlargement of the islets of Langerhans, resulting in glucagon hypersecretion. The lack of a detectable solid pancreatic tumor in an NME patient with a grossly elevated glucagon level suggests the possibility of GCA. Hypersecretion of the catabolic glucagon and secondary complications such as bacterial sepsis might lead to a fatal outcome in GCA patients, highlighting the paradox of an essentially benign endocrine neoplasm with a devastating outcome.

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Migratory stomatitis (ectopic geographic tongue) on the floor of the mouth

To the Editor: A 73-year-old woman was referred by her primary care physician with a complaint of "soreness underneath the tongue" whenever she ate spicy food. The duration of soreness was 1 month before seeking treatment. Her medical history was significant for hyperlipidemia, untreated hypertension, and hip replacement. The patient was a nonsmoker with no known hypersensitivities. Examination revealed a fissured tongue and slightly elevated annular red atrophic lesions with white borders on the dorsal, lateral, and ventral aspects of the tongue and on the floor of the mouth (Fig 1). The lesions could not be wiped away by gauze. The patient had full upper and partial lower dentures (not in contact with lesions). A clinical diagnosis of migratory stomatitis was established; the patient was reassured and recommended to avoid spicy food.

The entity of migratory stomatitis involves the tongue and other oral mucosa. The common migratory glossitis (geographic tongue) affects the anterior two thirds of the dorsal and lateral tongue mucosa of 1% to 2.5% of the population, with one report of up to 12.7% of the population.¹ The tongue is often fissured, especially in elderly individuals.¹ In the American population, a lower prevalence was reported among Mexican Americans (compared with Caucasians and African Americans) and cigarette smokers.²

Aside from occurring on the dorsal and lateral tongue, lesions infrequently involve the ventral tongue and buccal or labial mucosa. They are rarely reported on the soft palate. However, information about extra-lingual lesions (called ectopic geographic tongue) is sparse and found predominately in case reports.³ Lesions are characterized by periods of exacerbation and remission with varying durations and locations over time.³ A minority of patients complain of soreness upon consumption of spicy, acidic, or hot food, cheese, or alcoholic beverages. It is unclear why the condition becomes suddenly symptomatic many years after presentation.³ The pathogenesis of this phenomenon remains unknown.

The diagnosis is clinical only, with no need for further histopathological or other evaluations. Although also called "(oral) erythema migrans," this entity is unrelated to cutaneous erythema migrans,³ but may be related to psoriasis (4% of patients), seborrheic dermatitis, ectopic Reiter's



Fig 1. Atrophic lesions bordered by slightly elevated, thin, white margins on the floor of the mouth.

syndrome, and Crohn's disease.⁴ The differential diagnosis also includes recurrent aphthous stomatitis, oral candidiasis, lichen planus, lupus erythematosus, and other glossitis conditions. Usually, as in the presented case, these conditions are ruled out on the basis of patient history and clinical (oral and extra-oral) features. No treatment is indicated for migratory stomatitis. The clinician should reassure the patient that the condition is benign. When soreness is present, topical anesthetics, antihistamines, or corticosteroids may be useful.

Dermatologists and other caregivers may encounter this condition. To our knowledge, this is the first report in peer-reviewed literature of migratory stomatitis on the floor of mouth.

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Therapy-related leukemia cutis with histopathologic changes resembling xanthogranuloma

To the Editor: We report a rare case of therapy-related leukemia cutis with uncommon histological features. A 41-year-old woman had a 2-year history of stage IV CD30+ nodal anaplastic large T-cell lymphoma. She was treated with 6 courses of cyclophosphamide, epirubicin, vincristine, and prednisolone (CEOP). Six months after treatment, she developed acute myelogenous leukemia (AML), M4 type. Two courses of high-dose cytarabine were given without obvious response. On admission for a third course of chemotherapy for AML, her white blood cell count was 59,300 cells/ μ L (normal range, 4,000 to 10,000 cells/ μ L) with 91% blasts, hematocrit 34.8% (normal range, 34%-50%), and platelet count $33 \times 10^3/\mu$ L (normal range, $140 \times 10^3/\mu$ L to $450 \times 10^3/\mu$ L). Analysis of bone marrow cells revealed an abnormal karyotype of t(6;11)(q27;q23). Treatment was begun with gemtuzumab ozogamicin. One week after the second treatment, erythematous papules and plaques appeared on her face (Fig 1). Examination of a skin biopsy specimen from her right cheek showed diffuse infiltration of histiocyte-like mononuclear cells and some lymphoid cells in the reticular dermis (Fig 2). These features were initially thought to be a monomorphous xanthogranulomatous infiltrate that has been reported in association with leukemia. However, the mononuclear cells stained strongly with antibodies to CD68, lysozyme, CD43, partially positive for myeloperoxidase, and while staining was negative for CD1a, CD15, and CD30. This suggests that the infiltrate actually involved leukemic cells



Fig 1. Infiltrating erythematous papules and nodules on right cheek.