come from small, uncontrolled studies and case reports, they may have a role and are frequently used. Available data demonstrates a higher number and a shorter time interval for recovery of renal function. Use of prednisolone has probably contributed to the early and complete recovery of renal function in our case.

With more wide spread use of PPIs including the relatively newer agents like lansoprazole, the potential for this rare but serious adverse reaction needs to be given due importance. Prompt evaluation of renal function is warranted in patients who develop non-specific symptoms while taking PPIs. Early recognition will assist in preventing irreversible renal injury.

References

Case Report

Colloid milium: a rare cutaneous deposition disease

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Abstract

Colloid milium is a rare degenerative skin disorder known by the development of small translucent, yellowish brown papular nodules or plaques, generally located in sun exposed areas. Clinically they are of two types, adult and juvenile type. We present a case of adult type Colloid milium in a 60 years old female patient with clinical and histological findings unmistakable of the condition. She was treated with IPL (Intense Pulsed Light) laser following unsatisfactory response with dermabrasion.

Introduction

Colloid milium is a rare cutaneous deposit disease characterized by the presence of multiple, dome-shaped, translucent yellowish brown papules and plaques developing on sun-exposed areas of skin showing colloid in dermal papillae on histology.1,2 There are 2 broad variants namely an adult-onset type (nodular colloid degeneration), and a juvenile form.3,4 The origin of the colloid deposition in the dermis is thought to be due to degeneration of elastic fibers in the adult form and due to degeneration of UV-transformed keratinocytes in the juvenile form. No known figures exist on prevalence, but more than 100 case reports are present in the world literature.3 The condition is more frequent in fair-skinned individuals and adult form is more common in elderly males. The rare juvenile form occurs before puberty and is often familial. Patients are usually asymptomatic, but they may have transient itching in affected areas. Skin lesions are waxy, partially translucent, firm papules that occur in crops, ranging from 1-5 mm in diameter. Lesions reach their peak within 3 years, after which they are more or less static. Gelatinous material can be expressed on pressing the lesions. In the nodular form, larger nodules or plaques develop. Most common sites of involvement are cheeks, periorbital area, nose, ears, and neck. Lesions may also occur on the back of the hands and forearms.1,4,5 The classic adult and nodular forms are believed to be due to excessive sun exposure as the lesions mostly occurring on skin exposed sites in individuals with fair complexions and outdoor occupations.6 The juvenile form is inherited, perhaps suggesting an inherited susceptibility to UV light.5 Trauma, gas oils, phenols and long term use of hydroquinone bleaching creams may be contributory factors in addition to light and petroleum constituents.1,4,7 On histology, typical fissured eosinophilic colloid masses are seen in the dermis. Electron microscopy may sometimes be necessary to distinguish colloid from amyloid as under light microscopy both can show same staining pattern. Upon electron microscopy, wavy bundles of filaments are seen of colloid, in contrast to the straight, nonbranching, filaments of amyloid.8 Dermabrasion, cryotherapy, and diathermy treatments have been tried with limited success.1,4 The Er:YAG laser may be more successful than dermabrasion.9 Genetic counseling is advisable for the rare juvenile form. Sun avoidance seems sensible. We tried intense pulse light (IPL) with good response and to the best of our knowledge it was not used before.

Case Report

A 60 years old female presented with history of
yellow brown papules and plaques over forehead, nose, cheeks, and upper lip that appeared 6 years ago. Initially the patient had moderate itching and burning on exposure to sunlight. After a minor trauma to the nose lesions gradually increased to involve the forehead, cheeks, and upper lips over a period of 4 years and remained unchanged for the last 3 years. On examination lesions over forehead and nose appeared as nodular plaques (Figure 1), felt soft and released their gelatinous contents when pressed hard. Laboratory tests including complete blood cell count, liver functions, and urine analysis were within normal limits. Histological examination of one of the site revealed deposition of amorphous material with horizontal fissuring in papillary dermis. Wavy appearance of amorphous hyaline deposits due to horizontal clefts differentiated it from amyloidosis (Figure 2). There was also element of dermal elastosis. Dermabrasion had unsatisfactory response and due to poor compliance of the patient IPL laser was tried. IPL used was "Apollo-II (Swot, Ver- 3.0) made of Schanghai Wonderful Opto-Electric Tech Co, Ltd. Vessel removal system (VR) Mode-3 was used. Energy density was 25J/sec with First pulse duration (T1= 4ms), First delay (D1=20ms) and Second pulse (T2=5ms). Patient showed a considerable improvement with regression of nodules and plaques, after 4 sessions of treatment. Nodules and plaques regressed significantly resulting in smooth appearance of facial skin. She was advised two more sessions of IPL and then regular follow up after every three months for one year, but she never reported back and was lost to further follow up.

Discussion

Colloid milium is also called colloid degeneration of the skin or dermal hyalinosis. The condition may not represent a single entity and should be regarded as one of cutaneous deposit diseases. The rare juvenile form can be distinguished from a non-familial adult form by occurring in later life and histopathologically by colloid masses in the upper dermis and absence of elastosis, whereas in adult form, the colloid is located in the upper and mid dermis, with a layer of papillary dermis spared (Grenz zone). In the adult form solar elastosis is marked and closely approximated to the colloid. Hair follicles and sebaceous glands are well preserved. In the nodular form, the vast majority of the dermis is filled with colloid. Clinically besides papules and plaques, a nodular (nodular colloid degeneration of skin) form has been described in which lesions may be larger and may be single or multiple. Clinical and histological findings in our case suggested it to be a nodular variant of adult form of colloid milium. The patient was a house working female with no history of excessive (occupation) sun exposure, in contrast to common occurrence of this condition in elderly males having excessive sun exposure. The Er:YAG laser has been shown effective previously but we used IPL with satisfactory response. IPL is a broad spectrum, noncoherent, intense pulsed light source that delivers multiple wavelengths with controlled pulse durations and sequencing, which permits treatment of wide range of facial problems simultaneously (vascular, pigmented and infiltrative). Energy density and pulse duration used was similar to what we use for rosacea of the face. Likely mechanism in case of cutaneous deposit disease like Colloid milium would be reduction of vasculature and its effect on reorganization and remodeling of elastic as well as collagen tissue resulting in smoothening of skin. Hence it can be suggested as a new addition to therapeutic armamentarium of this disorder.
References

Case Report

Clear cell Papillary Cystadenoma of Epididymis, a Mimic of Metastatic Renal Cell Carcinoma

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Abstract
We discuss a case of 25 year old male who was evaluated for primary infertility following marriage. He had no previous history of urogenital complaints or abnormalities. In fact, his past medical history was unremarkable. On examination epididymal masses were found. Semen analysis showed azoospermia. Right epididymal mass was surgically excised. Histopathology showed an epididymal neoplasm composed of simple and complex papillary processes lining and filling the ducts. The tumor cells were clear and positive for cytoplasmic glycogen. Immunohistochemistry was also supportive. Diagnosis of clear cell papillary cystadenoma was made based on histopathological and immunohistochemical features.

Introduction
Papillary Cystadenoma of the epididymis is the second commonest benign neoplasm of this organ following adenomatoid tumor. It is a rare epithelial tumour which is thought to develop within the efferent ductules. It was first described in 1956. It may occur sporadically or as a manifestation of von Hippel-Lindau disease (VHL). Two thirds of patients with this neoplasms have von Hippel-Lindau disease. Metastatic renal cell carcinoma (RCC) is a close histologic mimic of this neoplasm and both are related to von Hippel-Lindau disease. It is important to differentiate between these two entities for the proper management of the patient.

Case Report
A 25 years old Asian male was evaluated for primary infertility. He was married since one year. There was no history of any urogenital complaints or abnormalities. His past medical and surgical history was unremarkable. On examination he was found to have bilateral painless epididymal masses. Right epididymal mass was 2 X 2 cm in size and was firm, mobile and non-tender. Spermatic cord and adnexae were unremarkable on palpation. Left sided testis also showed a small mass. Semen analysis revealed azoospermia. Serum Leutinizing hormone (LH) and Follicle stimulating hormone (FSH) levels were within normal ranges. Urinalysis and blood tests were normal. Fundoscopic examination and CT scan of brain showed no abnormality. Right epididymal mass was removed and sent for histopathological examination. Grossly the tumor was grey white in colour and measured 2 X 1.5 cm in size. Cut surface showed multiple cysts filled with yellowish serous fluid. Histologically, sections showed predominantly

Figure 1. Ducts showing papillary formations. H & E X 20.