with novel therapeutic modalities make shaping the prophylactic or acute management of patients with HAE a major challenge for medical professionals. This is why it is important to share experience, in order to match patients with the most appropriate medicinal products and treatment protocols. Appreciating the authors' effort and without the intention of diminishing the message conveyed by the description of these cases, we would like to point out that reading through their article raises several questions and leaves many details unclear. Nevertheless, arriving at a definite conclusion would require knowledge of the missing details.

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Optimizing the shave excision technique to aid accurate histological diagnosis

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Madam, Shave excision is an established surgical method for removing benign skin lesions for cosmetic and functional reasons.[1] With good technique, atypical melanocytic naevi including dysplastic naevi can be removed as a quick, cost-effective method of obtaining definitive histology. Processing shave biopsy specimens in the laboratory can result in artefactual changes which may cause difficulty for the pathologist to make an accurate histological diagnosis, especially when commenting on completeness of excision. Here we describe the use of a simple piece of cardboard which assists in the laying of the shave biopsy specimen, thereby minimizing tissue artefact and potential diagnostic difficulty.

Our routine practice is to perform shave excisions during consultations, thus not requiring theatre capacity. With strict aseptic technique, the skin is infiltrated with local anaesthetic and the lesion is then shave excised using the standard razor blade technique (Fig. 1a). The specimen is immediately placed on a small piece of cardboard (Fig. 1b). The rough surface of the cardboard, coupled with gentle pressure on the specimen, ensures good adherence of the shave biopsy specimen with the cardboard. Forceps may be used to tease out the periphery of the specimen if epidermal

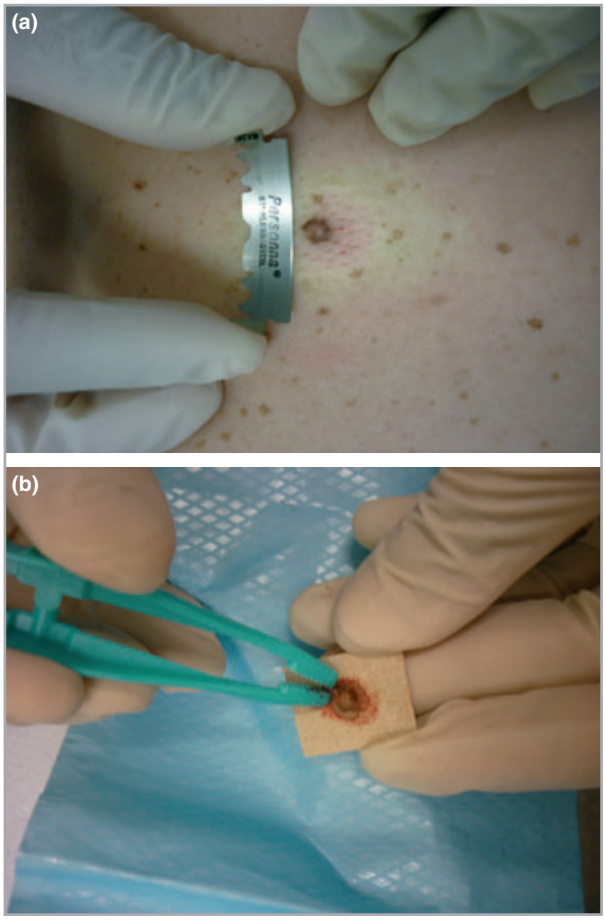

Fig 1. (a) Atypical melanocytic naevus excised from the back using the standard razor blade technique. (b) Shave biopsy specimen laid carefully on the rough surface of the cardboard and forceps used to tease out edges to prevent epidemal rolling.

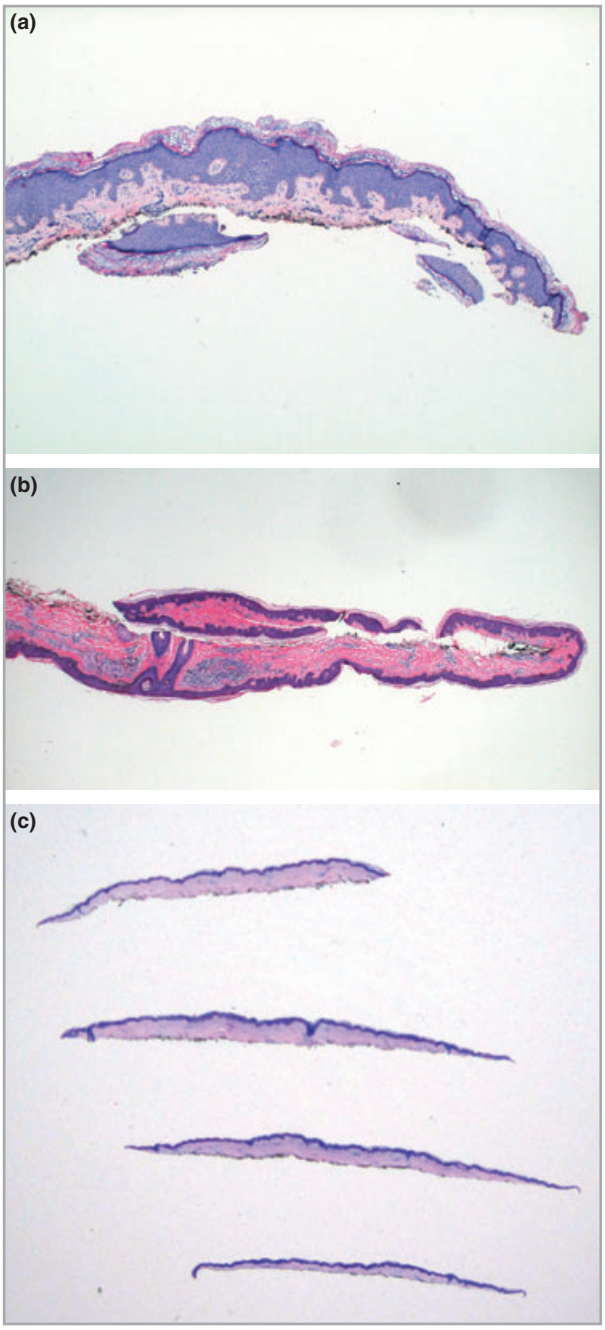

Fig 2. (a) Histology of a lesion which had not been placed on cardboard and shows marked folding at the ends of the specimen (haematoxylin and eosin; original magnification ×4). (b) This shave biopsy specimen was twisted during processing in the laboratory and was subsequently cross-cut (haematoxylin and eosin; original magnification ×4). (c) Scanning power view of a shave biopsy submitted on cardboard illustrating the complete tissue sample and allowing adequate assessment of symmetry and margins.

rolling is evident. The specimen overlying the cardboard is then placed into formalin for histological evaluation. Haemostasis of the wound is achieved by pressure or, if necessary, with aluminium chloride-soaked cotton buds, and the operative site is covered with a hydrocolloid dressing which the patient can easily change after 4 days, thereby avoiding a follow-up visit.

Shave biopsy specimens that are placed directly into formalin can result in difficulty in processing of the specimen in the laboratory. Figure 2a shows histology of a lesion which had not been placed on cardboard and shows marked folding at the ends of the specimen. Figure 2b shows histology of another lesion which reveals twisting of the specimen during processing in the laboratory and which subsequently was cross-cut. In both examples the specimen loses accurate assessment of architecture, most importantly symmetry. An artificial margin may also be created which hampers correct assessment of completeness of excision. These artefacts arise due to fixation of the specimen in a rolled shape which is the natural tendency of the shave specimen. Figure 2c illustrates the benefit of using the cardboard, with good representation of the histology of the specimen.

In our experience, modifying the razor blade technique by usage of a simple piece of cardboard assists not only laboratory technicians processing the shave biopsy specimens, but also pathologists reading the slides. We feel potential error can be avoided in relation to making an accurate histological diagnosis and to pathologists reporting on completeness of excision.

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The profilaggrin N-terminal domain is absent in pityriasis rotunda

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MADAM, Pityriasis rotunda (PR) is a rare keratinizing disorder characterized by round or oval patches that are hyper- or hypopigmented, well-demarcated plaques.[1] The main lesional sites are trunk and extremities. This disease entity was initially described in Japan by Toyama in 1906 and was termed tinea circinata.[1] This keratinizing disorder has frequently been reported in Japan, South Africa and the West Indies.[2,3] The incidence in caucasian populations appears to be very low. The aetiology of PR is at present unknown. There are several reports that suggest that PR is a form of acquired ichthyosis, a