firm, red-brown nodules grouped on linear or dermatomal arrangement. The extremities are the most frequently involved sites, particularly extensor surfaces, followed by the trunk, face and neck. Solitary piloleiomyoma usually presents as a reddish brown, smooth, and dome-shaped papule or nodule. In this case, like in our patient, the clinical diagnosis was challenging due to the translucent aspect and the presence of telangiectasia in the nodule basis. The histological examination sheds light on the diagnosis of piloleiomyoma.

Most leiomyomas are tender or painful as described in our patient. The pain or tenderness may be spontaneous or induced by cold, emotions, touch, trauma, or pressure. The pathogenesis of pain associated with these lesions is unresolved. Some authors have suggested that pain could be caused by local pressure of the cutaneous nerves, contraction of the arrector pili muscle or by injury [2]. The diagnosis may be facilitated by the painful character of the nodule. The differential diagnosis may be made with other painful tumors like eccrine spiradenoma, neurorna, glomus tumor, angiolipoma, neurolemmoma, and dermatofibroma [3], even if the clinical aspect was so unusual and does not really evoke any of these diagnosis. Surgical excision is the treatment of choice in painful solitary leiomyoma.

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References


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Letters to the editor

Lettres complexes surronded trum disorderly detected.

Parenchyma between hyperintense shows Multiple Discussion

Axial Figure T2-weighted image shows small innumerable hyperintense cystic lesions

Thick slab coronal MR cholangiopancreatography (MRCP) image shows high signal cystic lesions scattered throughout hepatic parenchyma with "starry sky" appearance and no communication between lesions and the normal-sized biliary system

Discussion

Multiple biliary hamartomas (MBH), also called von Meyenburg complexes is uncommon pathology. They correspond to focal disorderly collections of bile ducts lined by a biliary epithelium surrounded by abundant fibrous stroma. It belongs to the spectrum of fibropolycystic liver diseases. MBH result from embryologic ductal plate malformation involving the small interlobular bile ducts [1].

In most of cases, MBH are asymptomatic and incidentally detected. They are not associated with abnormal liver function tests. Only a few case reports have described cholangiocarcinoma associated with MBH but a causal relationship has not been proven yet [2]. Knowledge of their features on the different imaging modalities, particularly MRI, helps avoid misinterpretation of these lesions as hepatic metastases or micro abscesses. They typically appear as multiple small lesions, uniform in size, ranging from 1 to 20 mm, uniformly distributed into the liver, unlike liver metastasis [1-3]. On ultrasonography, there is no specific appearance; lesions can be hypoechoic or hyperechoic with a comet-tail artifact [3]. On computed tomography, lesions are hypodense with no enhancement on post-contrast images [3]. MRI is the most accurate imaging modality for the diagnosis of MBH. Cysts appear more abundant, are well defined, hypointense on T1 weighted images, very hyperintense on T2 and diffusion weighted images and they have no communication with the intrahepatic biliary tree. A "starry sky" appearance is characteristically seen on MRCP [2,4]. On post gadolinium images, they do not usually show contrast enhancement but some cysts can demonstrate early thin and regular peripheral rim enhancement or an enhancing mural nodule that can mimic metastasis [2,4]. When features on MRI and MRCP are typical in a patient who has no known primary neoplasm, histological examination of the liver is not needed.

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References


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