columnar epithelium, which showed positive immunohistochemical reaction to CK. The carcinoid component, composed of nests of uniform, chromogranin positive tumor cells, which showed up to 4 mitoses on 10 high power fields, infiltrated the whole thickness of appendiceal wall and extended to periappendiceal fat tissue. In conclusion, the incidence of neoplasms in appendicectomy specimens varies from 1% to 10% according to different studies. Hence, it is important to thoroughly examine the potentially inflamed appendices, particularly when there is no sign of acute pathologic condition.

ATYPICAL SYMPLASTIC GLOMUS TUMOR OF THE LEFT HALLUX

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Glomus tumors are benign perivascular tumors, which result from hyperplasia of normal glomus body, a specialized form of arteriovenous anastomosis that regulates heat. Occasionally, glomus tumors may exhibit some atypical histologic features and rarely can even metastasize. Here, we report a case of a symplastic glomus tumor, a variant of histologically atypical, but still benign glomus tumor. An 81-year-old male patient was surgically treated due to a tumor of his left great toe. Macroscopically, the tumor was well-circumscribed, measured 4x3x2.5 cm and was located in the subcutis. Histologically, it was encapsulated, composed of solid sheets of cells separated by vessels of a varying size. The neoplastic cells showed pronounced nuclear pleomorphism, hyperchromasia and occasional intranuclear inclusions. Mitotic rate was sparse, up to 2 mitoses on 50 high power fields, but proliferative rate measured immunohistochemically was extraordinarily high, about 25%. Tumor cells were immunohistochemically diffusely positive for SMA and desmin. According to classification of glomus tumors proposed by Folpe and coworkers, we declared this tumor as symplastic, considering marked cellular atypia, but the lack of other criteria that could point to its possible malignant behavior. In conclusion, glomus tumors may rarely present with atypical features, but in the absence of other criteria such as large size, deep location, high mitotic index or atypical mitotic activity, they should be considered merely as a consequence of degenerative change and not a sign of malignancy.

CLINICAL PRESENTATION OF A PATIENT WITH PALMOPLANTAR PUSTULAR PSORIASIS: CASE REPORT

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Palmoplantar pustular psoriasis is a rare, chronic dermatosis characterized by sterile pustules that develop within areas of erythema and scaling on the palms, soles or both. The minority of patients have chronic plaque psoriasis elsewhere. Focal infections and stress have been reported as triggering factors. Smoking aggravates the disease and negatively reflects on treatment success. The disorder occurs more commonly during the fourth decade of life. There is a slight female predilection. In most patients, lesions are asymptomatic; however, intermittent pruritus, and burning have been described. The histologic hallmark of palmoplantar pustular psoriasis is large accumulation of neutrophils within the stratum spinosum, known as spongiform pustule of Kogoj. Palmoplantar pustular psoriasis must be differentiated from other dermatoses, which are characterized by intraepidermal neutrophilic pustules including impetigo, superficial candidiasis, dermatophyte infection, superficial folliculitis, dyshidrotic eczema, and pustular drug eruption. Therefore, biopsy and histologic analysis is recommended in order to confirm the diagnosis. The aim of this case report is to present our patient suffering from palmoplantar pustular psoriasis, and to evaluate clinical presentation, diagnostic and therapeutic difficulties in this rare condition. A 38-year-old female patient was admitted to our hospital due to numerous sterile pustules on well-defined erythematous plaques with desquamation on the palms and soles three months before. The pustules were large (about five mm in diameter), and several stages of evolution of