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Umbilical Pilonidal Sinus as a Possible Complication of Depilation

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To the Editor:

Pilonidal sinus is a chronic inflammatory disorder caused by a hair fragment penetrating the skin and producing a foreign body reaction leading to the formation of a sinus coated with granulation tissue. The disease commonly occurs in the sacrococcygeal region, but can also develop in other locations where an anatomical cleft facilitates the accumulation of hair; these locations include between the breasts, the axilla, the perineum, or in the spaces between the fingers (in the case of barbers in particular). The occurrence of the disease in the navel is rare.

A 28-year-old man came to our clinic with inflammation and suppuration in his navel that had commenced some 2 months previously. Meticulous examination revealed a sinus tract from which a number of hair fragments were extracted. The patient, who was hirsute and whose weight was appropriate for his height, had been shaving his body with a razor since about 4 months previously. The removal of the hairs from the cavity alleviated the symptoms, and no recurrence was evident 6 months later.

Most cases of umbilical pilonidal sinus present as recurrent omphalitis with pain, suppuration and bleeding, or even as an umbilical mass. Pilonidal sinus typically affects young, hirsute men, often with poor personal hygiene. Obesity and sweating are other factors that facilitate hair entry in the epidermis.¹ The literature does not refer to depilation as a risk factor for the development of umbilical pilonidal sinus, possibly because the interest in depilation among men is a fairly recent development. In our patient, fragments of hair cut from the chest and abdomen very likely settled within the navel, resulting in the formation of the pilonidal sinus.

Diagnosis is clinical and based on the detection of hairs nesting deep within the navel. Pathology reveals a foreign-body granuloma, with an epithelium-lined tract leading to an area of fibrosis and granulation tissue enveloping the hair fragments. This entity should be included in the differential diagnosis of umbilical lesions, such as, for example, epidermal cysts, umbilical hernias, pyogenic granulomas, endometriosis, omphalomesenteric duct remnants,

urachal anomalies, and metastatic tumors.²

Most patients are cured by conservative treatment involving the extraction of the hair fragments and other debris from the cavity and, if necessary, the administration of oral antibiotics.^{3,4} Omphalectomy should only be resorted to for difficult-to-treat cases. In order to avoid the possibility of recurrence, navel reconstruction is not recommended, it being preferable to allow the surgical wound to heal by second intention.

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Pigmented Eccrine Poroma

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To the Editor:

Eccrine poroma is a rare tumor that displays variable morphology.

Its clinical variability means it can adopt the appearance of other cutaneous tumors, whereby

diagnosis is only rarely made on a clinical basis and must be confirmed by pathology.

We present a case of pigmented eccrine poroma.

A 42-year-old woman was referred to us for the assessment of a pigmented lesion on the palmar surface of the third finger of the right hand. She had no relevant medical or surgical history and was not receiving any treatment.

The patient reported that the lesion had appeared on the palmar surface of the second phalanx of the third finger of the right hand 10 months previously. The lesion had grown slowly and had bled several times in the last month when knocked.

Examination revealed a pigmented, papular, oval-shaped lesion, 5 mm in diameter, that was uniform, clearly defined, and had an irregular verrucous surface. No ulceration was present (Figure 1).

Histopathology revealed thickening of the epidermis in broad anastomosed bands of small homogeneous, cuboidal, cells with round basophilic nuclei. The edges of the tumor were clearly defined with no evidence of peripheral palisading, and intercellular accumulations of pigment were present (Figures 2 and 3).

These clinicopathologic findings led to diagnosis of pigmented eccrine poroma.

The lesion was completely excised and the patient has progressed favorably to date with no recurrence of the lesion.

Pigmented eccrine poroma is a rare skin adnexal tumor and accounts for less than 1% of primary cutaneous lesions.¹ The term *poroma* refers to a group of benign skin adnexal tumors with poroid or distal ductal differentiation which can be of eccrine or apocrine lineage.

The various histopathologic variants of poroma (hidroacanthoma simplex,² classic poroma, dermal duct tumor, and apocrine poroma) have clinically distinct morphologies,³ and there have been occasional descriptions of forms showing combinations of different neoplastic patterns.

Classic poroma is a tumor that generally occurs in patients aged

over 40 years, with a slight predominance amongst women. These tumors have generally been reported to be found on the palms of the hands (10%) and soles of the feet (65%), although they can occur in many other locations.⁴

Clinically, poroma can vary widely in form, consistency, and color. In most cases they occur as a solitary lesion in the form of an asymptomatic papule or nodule (with the possibility of bleeding and pain following trauma), in well-defined, sessile, or pediculate form, sometimes developing a papillomatous surface, and measuring between 1 and 5 cm in diameter. The color of the lesion can range from that of normal skin, or similar, to that of pyogenic granuloma or hemangioma. Exceptional cases of pigmented forms have been described,⁵ as is the case here.

Histologically, there is a discrete proliferation of cuboidal keratinocytes with rounded or oval monomorphic nuclei and scarce cytoplasm, while the uniform poroid cells form islands. These cells are similar to those of the peripheral cell layer in the most distal portion of the eccrine and apocrine duct. Clearly defined areas of necrosis in the center of the islands of tumor cells are characteristic of the condition. Cystic spaces can also present along with areas of keratinization, clear and pallid cells, dendritic melanocytes, and melanin, etc.⁶

Poroma behaves biologically like a benign neoplasm, with the possibility of local persistence if incompletely excised.

It is important to note that the clinical characteristics of poroma are not specific. It can adopt the appearance of other cutaneous tumors, and as a result, differential diagnosis should include conditions such as pyogenic granuloma, hemangioma, seborrheic keratosis, fibroma, and even nodular and amelanotic melanomas.⁷ Clinical examination rarely proves sufficient for diagnosis and histologic confirmation must be obtained.



Figure 1. Pigmented papular tuberculous lesion on the finger.

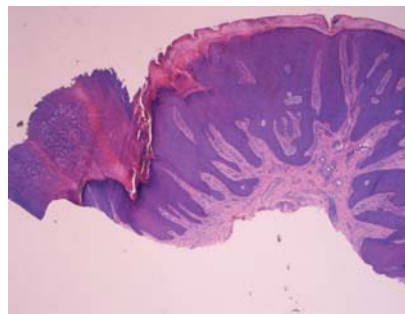


Figure 2. Hematoxylin-eosin staining, $\times 20$.

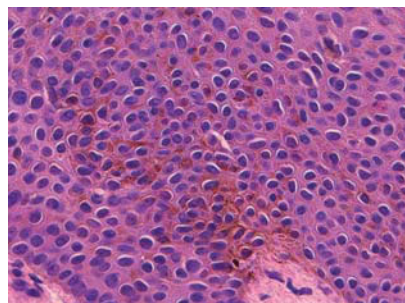


Figure 3. Hematoxylin-eosin staining, $\times 400$.

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Low-Dose Isotretinoin For Treatment of Chronic Discoid Lupus in Women of Childbearing Age

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To the Editor:

We present the case of a 29-year-old woman diagnosed with systemic lupus erythematosus in 1988 on the basis of malar erythema, photosensitivity, arthralgia, thrombocytopenia, lymphopenia, and positive results for antinuclear and anti-DNA antibodies. She consulted in August 2004 with multiple erythematous plaques with atrophic centers on the upper region of the trunk and face, along with erythematous lesions with a hyperkeratotic appearance on both palms (Figure 1), with onset several months previously. Both types of lesion were compatible with lupus. At the time of consultation the patient was being treated with prednisone, mycophenolate, and chloroquine, without improvement in the cutaneous lesions. Treatment was prescribed with isotretinoin 40 mg/d, with agreement from the patient to use effective means of contraception. A rapid response was observed and the drug was well tolerated, so treatment was maintained for 6 months. The palmar lesions reappeared from 1 month after the drug was withdrawn. Topical treatment was administered for approximately a year to no effect, leading to initiation of treatment with isotretinoin at a dose of 20 mg/d in order to reduce the toxicity of the treatment. A slower improvement was seen with the new dosage, although from the fifth month of treatment the results were similar to those seen at the

end of the 40 mg/d cycle (Figure 2). The lesions remained stable for 12 months, with no significant changes in triglycerides or hepatic enzymes. The patient used safe methods of contraception during the treatment period. There were no side effects apart from cheilitis and slight xerosis on the face.

Chronic discoid lesions are one of the most common forms of cutaneous lupus erythematosus.¹ These are most commonly found on the face, scalp, and the ears, although palmar lesions are also possible.

Chronic discoid lupus erythematosus can be treated with various topical drugs, like potent corticosteroids,² or imiquimod 5%,³ as well as systemic treatments like thalidomide, hydroxychloroquine, or acitretin. The last 2 are first-line drugs with similar levels of effectiveness,² although acitretin has more associated side

effects. Side effects include cutaneous xerosis, cheilitis, gastrointestinal disorders, increased serum levels of triglycerides, and high risk of teratogenic effects, which oblige patients to use contraceptive measures during treatment and for 2 years after the drug is discontinued.

Meanwhile, isotretinoin has been shown to be effective in the treatment of chronic discoid lupus erythematosus, and it can also be employed as a maintenance treatment at doses of 40 mg on alternate days.⁴ This treatment has similar side effects to acitretin but a lower risk of teratogenesis, which means that female patients prescribed the drug need only take contraceptive measures during treatment and for a month after this is suspended. In the case described here, the patient was planning a pregnancy in the medium term, whereby acitretin was rejected in favor of isotretinoin.



Figure 1. Hyperkeratotic erythematous lesions on both palms.



Figure 2. Improvement of lesions following 5 months of treatment with isotretinoin (20 mg/d).