Actas Dermosifiliogr. 2015;106(8):675–695

ACTAS
Dermo-Sifiliográficas

Full English text available at
www.actasdermo.org

CASE AND RESEARCH LETTERS

Cell Phone-Induced Chondrodermatitis Nodularis Antihelicis☆

Condrodermatitis nodular del antihélix por teléfono móvil

Chondrodermatitis nodularis (CN) helicis—or, less frequently, antihelicis—is a painful benign lesion that usually affects patients between 50 and 70 years of age and is more common in men.[1] The exact etiology of the process is unknown, although impairment of the vascular supply caused by repeated pressure on the region is the most widely accepted theory.

We report the case of a 54-year-old man who worked as a freight manager—an occupation that entails more than 6 hours of mobile telephone use per day—and had no past medical history of interest. The patient had a painful lesion on the left auricle that had appeared nearly 1 year earlier. Physical examination revealed an ulcerated, erythematous, rounded, nodular lesion on the antihelix that was painful to touch and had relatively well-defined borders (Figs. 1 and 2). Histologic findings ruled out malignancy and were consistent with a diagnosis of CN. The patient said that he often held a mobile telephone against the site of the lesion for long periods while working. We therefore opted for a conservative approach and advised the patient to use a hands-free device. Clinical improvement was observed after 3 months. After 1 year of follow-up, complete resolution of the lesion was achieved and no recurrence was observed (Fig. 3).

The exact incidence of CN is unknown because the entity is not widely studied.[2] Sustained pressure on the auricular region has been postulated as a mechanism of etiology and pathogenesis. Excessive telephone use can cause perichondrial vasculitis, which can lead to the degeneration of the auricular cartilage.[3] The differential diagnosis should include neoplastic and preneoplastic lesions such as basal cell carcinoma, squamous cell carcinoma, and actinic keratoses; histologic examination is sometimes necessary to rule out these possibilities.[4] The most widely used conservative treatments are pressure-relieving devices, topical or intralesional corticosteroids, topical nitroglycerine, and photodynamic therapy, and the efficacy of these techniques is highly variable.[5–7] Narrow elliptical skin excision followed by the shaving of the affected underlying cartilage is among the most widely used surgical techniques and has cure rates of up to 90.4% for lesions on the helix and 62.5% for lesions on the antihelix.[8] In the case of our

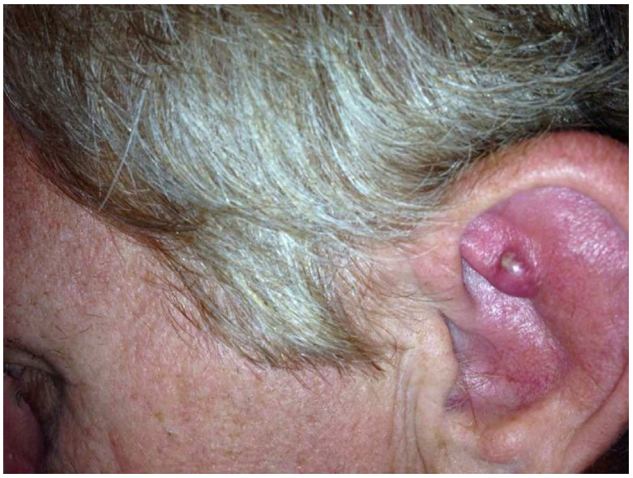

Figure 1 Ulcerated, erythematous, rounded, nodular lesion with relatively well-defined borders on the antihelix.

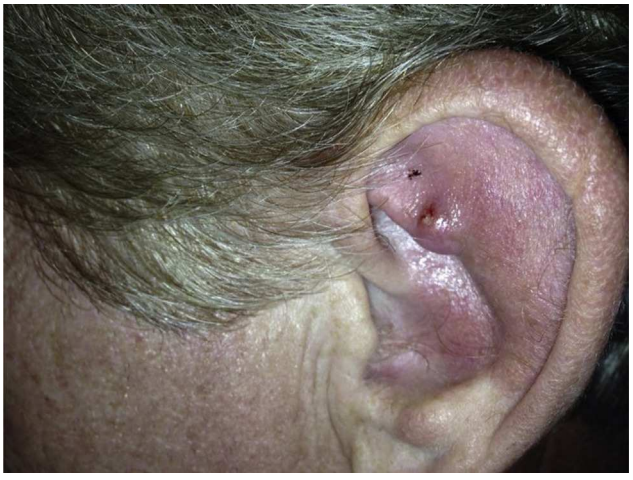

Figure 2 Lesion after skin biopsy.

☆ Please cite this article as: Ortiz A, Martín P, Domínguez J, Conejo-Mir J. Cell Phone-Induced Chondrodermatitis Nodularis Antihelicis. Actas Dermosifiliogr. 2015;106:675–676.

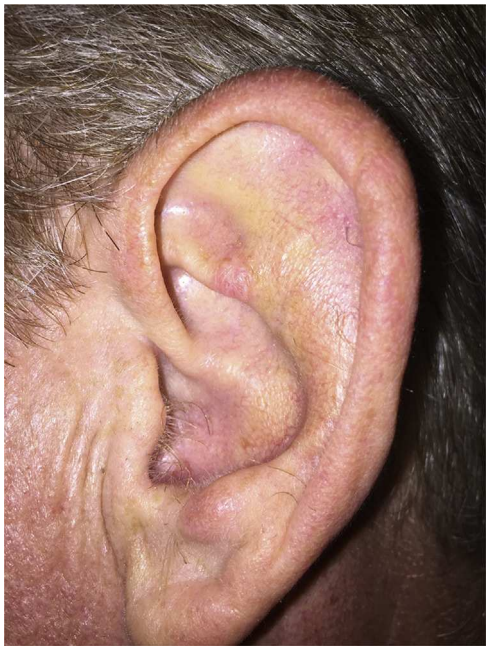

Figure 3 Resolved lesion 1 year after the patient started using a hands-free device.

patient, the use of a hands-free device to avoid recurrent trauma in the region was sufficient to cure the lesion.

We have presented a case of CN antihelicis caused by work-related mobile telephone use for many hours a day. Although this etiology is not reported frequently in the literature, physicians should take into account the widespread use of mobile telephones when trying to determine the cause of this dermatosis and prescribe treatment.

References

1. Thompson LD. Chondrodermatitis nodularis helicis. Ear Nose Throat J. 2007;86:734–5.
2. Chan HP, Neuhaus IM, Maibach HI. Chondrodermatitis nodularis chronica helicis in monozygotic twins. Clin Exp Dermatol. 2008;34:358–9.
3. Upile T, Patel NN, Jerjes W, Singh NU, Sandison A, Michaels L. Advances in the understanding of chondrodermatitis nodularis chronica helices: The perichondrial vasculitis theory. Clin Otolaryngol. 2009;34:147–50.
4. Wagner G, Liefeith J, Sachse MM. Clinical appearance, differential diagnoses and therapeutical options of chondrodermatitis nodularis chronica helicis Winkler. J Dtsch Dermatol Ges. 2011;9:287–91.
5. Gilaberte Y, Frias MP, Pérez-Lorenz JB. Chondrodermatitis nodularis helicis successfully treated with photodynamic therapy. Arch Dermatol. 2010;146:1080–2.
6. Garrido Colmenero C, Martínez García E, Blasco Morente G, Tercedor Sánchez J. Nitroglycerin patch for the treatment of chondrodermatitis nodularis helicis: A new therapeutic option. Dermatol Ther. 2014;27:278–80.
7. Yélamos O, Dalmau J, Puig L. Condrodermatitis *nodularis helicis* tratada con éxito con nitroglicerina al 2% en gel. Actas Dermosifiologr. 2013;104:531–2.
8. Rex J, Ribera M, Bielsa I, Mangas C, Xifra A, Ferrándiz C. Narrow elliptical skin excision and cartilage shaving for treatment of chondrodermatitis nodularis. Dermatol Surg. 2006;32:400–4.

A. Ortiz,* P. Martín, J. Domínguez, J. Conejo-Mir

Unidad de Gestión Clínica de Dermatología, Hospital Universitario Virgen del Rocío, Seville, Spain

* Corresponding author.
E-mail address: ale.ortizprieto@hotmail.com (A. Ortiz).

Alopecia and Hirsutism in a Postmenopausal Woman as the Presenting Complaint of Ovarian Hilus (Leydig) Cell Tumor☆

Alopecia e hirsutismo en una mujer posmenopáusica como forma de presentación de un tumor de células de Leydig hiliar del ovario

To the Editor:

Female androgenetic alopecia is one of the main causes of hair loss, and affects 50% of women in their lifetime.[1] Alopecia and hirsutism as a manifestation of hyperandrogenism in postmenopausal women can have various causes, ranging from normal physiological changes to an ovarian or adrenal tumor. Recommended tests in any woman presenting with alopecia are a detailed clinical history, physical examination, general blood tests (including complete blood count and thyroid stimulating hormone and ferritin levels) and a hormone study with measurement of dehydroepiandrosterone sulfate and total and free testosterone levels.

We present the case of a 65-year-old woman who presented with a 1-year history of hair loss and black facial hair. There was no past history of alopecia, hirsutism, or hyperandrogenism. Her history was remarkable for cardiovascular risk factors (hypertension, dyslipidemia, and diabetes mellitus), and she was also being monitored by the endocrinology department for euthyroid goiter. The physical examination showed frontoparietal hair loss in a triangular-shaped pattern (Fig. 1 A) and diffuse thinning on the crown (Fig. 1 B). These findings were consistent with male-pattern female hair loss grade II in the Ebling classification system. The patient also had hirsutism (Ferriman-Gallwey score 9), located predominantly on the face and sides of the neck but also in the chin area (Fig. 2). Examination of the external genitalia revealed an enlarged clitoris. There were no other signs of virilization, such as voice deepening or increased muscle bulk.

☆ Please cite this article as: Berbegal L, Albares MP, De-Leon FJ, Negueruela G. Alopecia e hirsutismo en una mujer posmenopáusica como forma de presentación de un tumor de células de Leydig hiliar del ovario. Actas Dermosifiliogr. 2015;106:676–678.