

Table 3 Signs of Atopy.

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| Xerosis |
| Ichthyosis vulgaris |
| Keratosis pilaris |
| Follicular prominence |
| Hyperlinearity of the palms and soles |
| Double palpebral fold |
| Palpebral hyperpigmentation associated with edema and lichenification |
| Horizontal folds in the central region of the anterior neck |
| Thinning or absence of the lateral portion of the eyebrows |
| White dermographism |
| Pityriasis alba |
| Lichenification on the dorsum of the hands and fingers and of the anatomical snuffbox |
| Areolar eczema |
| Digital pulpitis |
| Juvenile plantar dermatitis |
| Atopic cheilitis |
| Prurigo simplex |

Adapted from Cohen DE and Jacob SE,¹ Cohen DE and de Souza A,³ Wilkinson SM and Beck MH,⁴ Beck MH and Wilkinson SM,⁵ and Bieber T and Busmann C.¹⁰

aim of this article has been to present the initial clinical evaluation guideline used in our center in the hope that it will help dermatologists in their evaluation of patients with contact eczema. The medical history and dermatologic examination will orient the diagnosis and the search for the etiology, will establish the relevant additional tests, and will facilitate patient education. The German guideline recommends secondary prevention measures in high-risk groups through avoidance of exposure to known irritants and allergens by the use of appropriate skin protection (level B evidence).⁶ Finally, the role of the dermatologist is essential in the identification of high-risk patients and the adoption of appropriate primary and secondary measures of prevention.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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A. Imbernón-Moya,^{a,*} F.J. Ortiz-de Frutos,^b
A.M. Delgado-Márquez,^b F. Vanaclocha-Sebastián^b

^a *Servicio de Dermatología, Hospital Universitario Severo Ochoa, Leganés, Madrid, Spain*

^b *Servicio de Dermatología, Hospital 12 de Octubre, Madrid, Spain*

* Corresponding author.

E-mail address: adrian.imber88@hotmail.com

(A. Imbernón-Moya).

Clear Cell Acanthoma of the Areola and Nipple[☆]



Acantoma de células claras de la aréola y el pezón

To the Editor:

Clear-cell acanthoma was described by Degos et al.¹ in 1962 as a benign epidermal tumor. It usually manifests clinically as

a single, slow-growing, dome-shaped reddish papule or nodule with a peripheral desquamating collarette. The surface shows fine desquamation and a vascular pinpoint pattern and it has a tendency to bleed on minimal trauma. Clear-cell acanthoma usually arises on the distal areas of the legs of middle-aged or elderly persons, and its diameter varies between 5 and 20 mm.² However, atypical sites and clinical forms and multiple lesions have been described, and even spontaneous regression.^{2–4} This, together with its histological characteristics, has led to a discussion of whether it is a benign tumor or reactive hyperplasia secondary to chronic inflammation; even the term clear-cell acanthosis has been proposed.³ Histology is characteristic, with a well-defined area of psoriasiform epidermal hyperplasia, in which the keratinocytes present a pale cytoplasm. There are interposed thick and thin layers, a tendency to acanthosis,

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particularly centrally, and fusion of the crests. In addition, mild spongiosis is observed, with neutrophil exocytosis, which can lead to the formation of small intraepidermal abscesses and thinning of the suprapapillary surfaces. The surface shows parakeratotic scales. Staining with periodic acid Schiff (PAS) confirms the presence of glycogen in the palisading cells.² Lesions arising in the areola of the breast have only been reported very rarely.

Our patient was a 74-year-old woman with no family history of interest. Important findings in her personal past history were congenital hypothyroidism, systemic hypertension, dyslipidemia, and an ischemic stroke in 2012. Her long-term treatment included levothyroxine, simvastatin, omeprazole, enalapril, and acetylsalicylic acid. She did not report any personal history of atopic dermatitis or psoriasis. She was seen in dermatology outpatients for the appearance a year earlier of a reddish, exudative, desquamating lesion in the areola of the right breast. The lesion had bled occasionally. She had been treated with various topical corticosteroids, the names of which she did not remember, with no improvement. She had also been seen in the breast pathology unit of our hospital, and a mammography had been performed, which was reported as normal.

Dermatologic examination revealed the presence of a well-defined, desquamating erythematous plaque with a slightly shiny surface in the upper outer quadrant of the areola of the right breast (Fig. 1A). The plaque measured 5 × 5 cm. Biopsy was performed on a clinical suspicion of Paget disease. This showed psoriasiform hyperplasia of the epidermis with neutrophil exocytosis, thinning of the

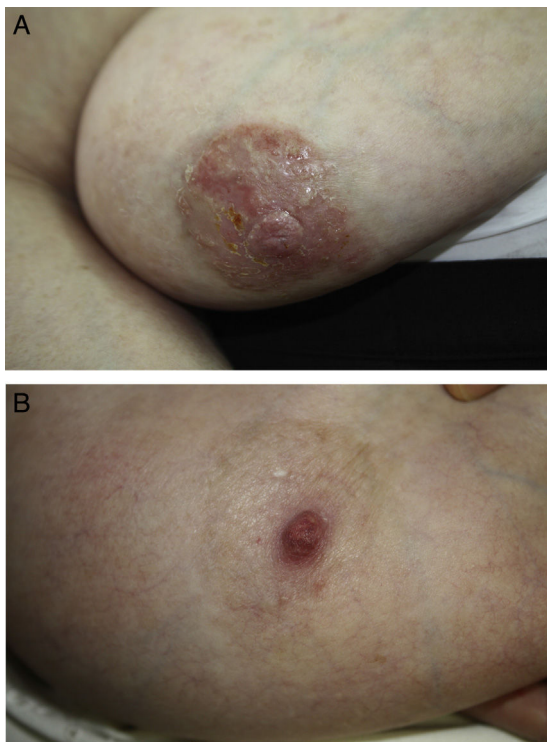


Figure 1 A, Well-defined, flaking, exudative erythematous plaque in the areola of the right breast. B, Complete resolution of the lesion in the areola of the right breast after 6 months of topical therapy.

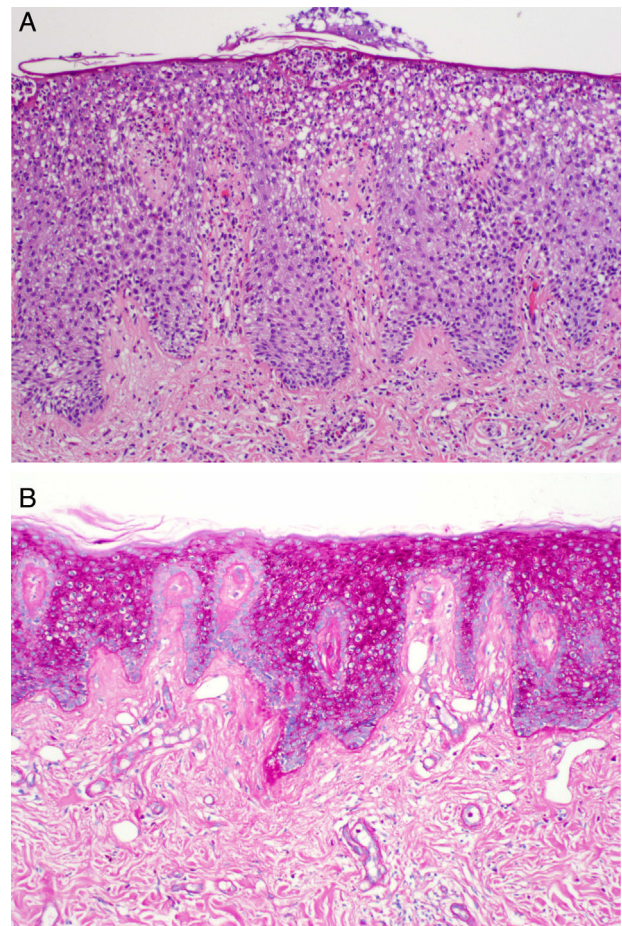


Figure 2 A, Agranulosis, spongiosis, and neutrophil exocytosis with subcorneal microabscesses and sheets of parakeratosis. Hematoxylin and eosin, original magnification ×100. B, Cells with abundant, clear, periodic acid Schiff-positive cytoplasm. Periodic acid Schiff, original magnification ×80.

granular layer, and cells with abundant pale cytoplasm (Fig. 2A); PAS staining is shown in Fig. 2B. The findings were compatible with clear-cell acanthoma.

Given the benign and asymptomatic nature of the lesion, we decided jointly with the patient and her family to adopt a wait-and-see approach. Treatment was started with 0.1% gentamicin sulfate plus 0.05% betamethasone dipropionate cream twice a day for 3 weeks. This achieved a marked improvement, and the treatment was therefore reduced to a single application twice a week, leading to complete resolution of the lesion after 6 months of treatment (Fig. 1B). No recurrence was observed in the 6 months after the interruption of treatment. The patient has not developed any other skin lesions during follow-up.

The first reported case of clear-cell acanthoma localized in the areola was published by Kim et al.⁵ in 1999; their patient, who had a history of atopic dermatitis, presented with eczema. Since that time only 7 other cases of clear-cell acanthoma localized in the nipple or areola have been reported.⁶⁻⁹ All have presented as eczematous lesions, except for the one published by Park et al.,⁸ which had a polypoid morphology. A history of atopy was found in 4 patients, including our patient, though other previous or

concomitant dermatoses were not reported.⁵⁻⁸ There is a clear female predominance at this site, with only 1 case occurring in a 26-year-old man.⁷ The size of the lesions varied between 2 × 2 cm and 4 × 4 cm.^{6,9} The preferred treatment options have been surgery and cryotherapy, and no recurrences have been observed. Four cases, including the one we report, were treated with corticosteroids, observing complete resolution in our patient and in 1 patient who used 0.5% clobetasol cream twice a day for several weeks.^{7,9}

In conclusion, we have presented a new case of clear-cell acanthoma in the areola and nipple, a rare site. We draw attention to the need to include this entity in the differential diagnosis of long-standing eczematous lesions of the nipple. The remission observed with a high-potency topical corticosteroid is a finding that supports the idea that clear-cell acanthoma may be a reactive process of the epidermis.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Y. Hidalgo-García,^{a,*} P. Gonzálvo,^b S. Mallo-García,^a C. Fernández-Sánchez^a

^a *Servicio de Dermatología, Hospital de Cabueñes, Gijón, Asturias, Spain*

^b *Servicio de Anatomía Patológica, Hospital de Cabueñes, Gijón, Asturias, Spain*

* Corresponding author.

E-mail address: yhidalgo@yahoo.es (Y. Hidalgo-García).

Leukocytoclastic vasculitis related to cocaine-adulterated levamisole



Vasculitis leucocitoclástica relacionada con cocaína adulterada con levamisol

Cocaine consumption has been increasing around the world in recent years and the associated complications are thus becoming more and more common.¹ Levamisole is often found in contaminated cocaine and can increase the length and intensity of the stimulant effect of this recreational drug.^{2,3}

Case description

A 47-year-old man with no medical background of note attended the dermatology department for a 1-month history of painful skin lesions on both ears. He otherwise felt well. On further questioning, he denied having taken any new or different prescription drugs and reported no prodromal symptoms. However, he did state he was a smoker and a user of cocaine since the age of 25 years; of note, he had sniffed cocaine 3 days before the onset of the lesions.

At presentation, symmetrical, bilateral erythematous-violaceous patches were observed on his ears (Fig. 1) and on the lateral walls of the abdomen (Fig. 2). Over the following

days, the lesions became infiltrated edematous papules and plaques that subsequently progressed to ulcerated necrotic plaques with an erythematous halo.

Full blood count and biochemistry were normal, including liver and kidney function tests. Urinalysis was unremarkable. Autoimmune screening revealed a polyclonal hypergammaglobulinemia, positive anticardiolipin M (48 U/ml), and positive antinuclear antibodies (titer, 1:160) with a speckled pattern. Complement was normal and the extractable nuclear antibodies panel (Smith, ribonucleoprotein, Ro, La, Scl-70, Jo-1), double-stranded DNA, antineutrophil cytoplasmic antibodies (ANCA), and cryoglobulins were negative. Serology for human immunodeficiency virus (HIV), hepatitis C virus (HCV) and hepatitis B virus (HBV) were negative and coagulation studies were normal. Chest X-ray did not show any relevant features. A full-thickness skin biopsy showed a leukocytoclastic vasculitis of the superficial and deep dermal and subcutaneous vascular plexuses, with some thrombotic features (Fig. 3). Urine drug screening was not performed. Based on these tests, we made a diagnosis of cutaneous leukocytoclastic vasculitis secondary to the use of levamisole-contaminated cocaine. The patient was treated with topical copper sulfate 1:1000 and betamethasone dipropionate, 0.05%, for 2 weeks, with an excellent response and complete clearance of the lesions without scarring, and no new lesions developed. The patient did not attend follow-up appointments.