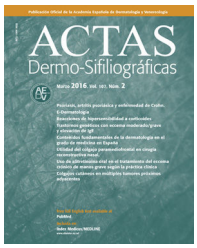
Actas Dermosifiliogr. 2017;xxx(xx):xxx–xxx

ACTAS Dermo-Sifiliográficas

Full English text available at www.actasdermo.org



CASE AND RESEARCH LETTER

Dermoscopy of Erythromelanosis Follicularis Faciei et Colli

Dermatoscopia de erythromelanosis folicular faciei et colli

Dear Editor:

Erythromelanosis follicularis faciei et colli (EFFC) is a rare pigmentary disease of unknown etiopathogenesis typically affecting the face/neck of children or young adults, which is clinically characterized by the combination of bilateral/symmetrical brownish pigmentation and erythema, associated with more or less evident follicular plugging.[1] Of note, such a condition is often associated with keratosis pilaris on the arms and shoulders, thereby letting some authors speculate that EFFC could be a variant of this latter dermatosis.[1] Not uncommonly, EFFC is mistaken for other similar pigmentary/erythematous dermatoses involving the aforementioned districts, with consequent diagnostic errors/delays and prescription of inappropriate therapies.[1] Over the last few years, several studies have shown that dermoscopic examination may be useful to assist the diagnosis of general skin diseases.[2–5] We here describe for the first time the use of dermoscopy as a noninvasive diagnostic aid in a case of EFFC, comparing its dermoscopic findings with those detectable in other conditions which classically enter into the differential diagnosis.

A 33-year-old man presented with a 6-year history of progressively worsening, asymptomatic, reddish-brown pigmentation associated with slight roughness on the cheeks, temples, lateral aspects of the nose, and frontal area (Fig. 1). Polarized light dermoscopic examination (carried out with DermLite DL3×10; 3Gen, San Juan Capistrano, CA, USA) revealed whitish scales and numerous whitish follicular keratotic plugs over a reddish-brown background; moreover, several gray-blue granules (peppering) were also evident in the perifollicular and interfollicular areas (Fig. 2). Histological examination showed slight orthokeratosis, follicular hyperkeratosis, increased basal layer pigmentation, perivascular and periadnexal lymphocytic infiltrate, and pigmentary incontinence with dermal melanophages (Fig. 2b), thus leading to the diagnosis of EFFC. Topical tacalcitol was prescribed and the use of sunscreen was recommended, with significant improvement of the clinical picture after eight weeks.

Dermoscopic findings seen in our instance of EFFC are related to the peculiar histological features which characterize this condition,[1,6] with follicular plugging, scaling, peppering, and reddish-brown background respectively corresponding to hyperkeratotic hair follicles, orthokeratosis, pigmentary incontinence/dermal melanophages, and dermal vasodilation/hyperpigmentation of the basal layer.[1,6] Such a dermoscopic picture is similar to that reported in a recent case of erythrosis pigmentosa peribuccalis, a pigmentary dermatosis presenting as brownish-red pigmentation and small papules around the mouth and nose, which displayed erythema, scaling, yellowish follicular keratotic plugs, and perifollicular grayish globules/dots.[7] These similarities are easily explained by the fact that both such disorders may share several histological features, so much so that they are considered to be part of the same condition spectrum by some authors.[7] Interestingly, the detection of the above-mentioned dermocopic features might come in handy in the noninvasive distinction of EFFC from its main differential diagnoses as the latter typically show different features. In particular: lichen planus pigmentosus usually displays diffuse, structureless, brownish pigmentation and/or fine/coarse, gray-blue/brown dots/globules[8]; Riehl's melanosis constantly features brownish pseudonetwork, gray dots/granules and telangiectatic vessels[9]; poikiloderma of Civatte commonly shows structureless brownish pigmentation and telangiectatic vessels, with or without whitish areas (personal observations); melasma typically presents light yellow-brown uniform patches, with or without dark brown patches and capillary network[10]; keratosis pilaris rubra atrophicans faciei frequently displays whitish follicular plugs over a reddish background with or without telangiectatic vessels (personal observations); demodicidosis mainly shows the so-called ''Demodex tails'' (creamy/whitish gelatinous threads representing the presence of the mite itself under magnification) protruding out of follicular openings, ''Demodex follicular openings'' (round and coarse follicular openings containing light brown/grayish plugs surrounded by an erythematous halo), erythema and whitish scaling[3]; keratosis pilaris often features coiled/twisted hair embedded in the horny layer, sometimes associated with perifollicular erythema and vascular ectasia (keratosis pilaris rubra)[4]; and follicular

http://dx.doi.org/10.1016/j.ad.2017.04.016

Please cite this article in press as: Errichetti E, et al. Dermoscopy of Erythromelanosis Follicularis Faciei et Colli. Actas Dermosifiliogr. 2017. http://dx.doi.org/10.1016/j.ad.2017.04.016

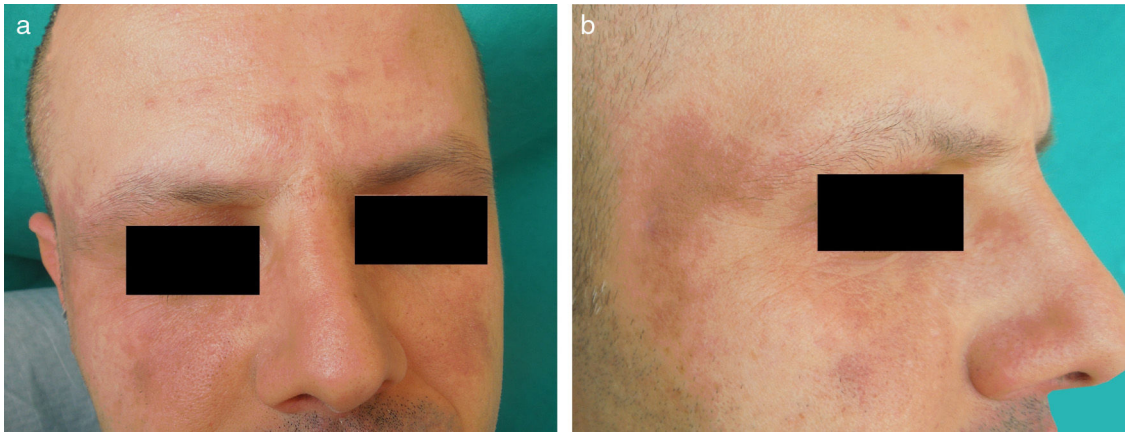


Figure 1 Clinical examination shows irregular areas of reddish-brown pigmentation of the cheeks, temples, lateral aspects of the nose, and frontal area (a and b).

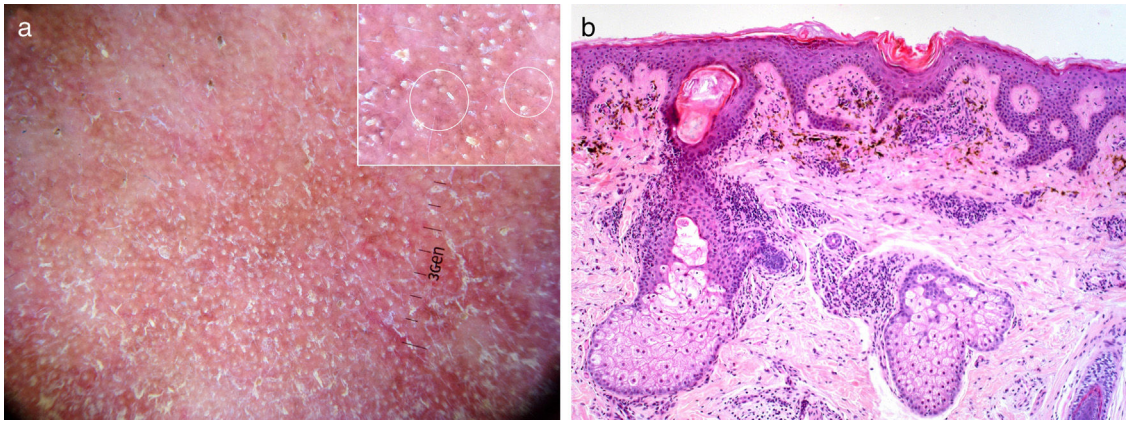


Figure 2 Polarized light dermoscopic examination displays whitish scales and numerous follicular keratotic plugs over a reddish-brown background; moreover, several perifollicular and interfollicular gray-blue granules (peppering) are also evident in the box (a). Histology reveals findings consistent with a diagnosis of erythromelanosis follicularis faciei et colli, i.e. slight orthokeratosis, follicular hyperkeratosis, increased basal layer pigmentation, perivascular and periadnexal lymphocytic infiltrate, and pigmentary incontinence with dermal melanophages (hematoxylin and eosin stain 200×) (b).

lichen planus reported to show follicular keratotic plugs without broken or twisted hairs.[4]

In conclusion, this paper emphasizes that dermoscopy might be used as an auxiliary tool in the noninvasive differential diagnosis of EFFC. Further studies are obviously needed to confirm our preliminar observations.

Conflicts of interest

The authors declare that they have no conflicts of interest.

References

1. Silva RS, Fonseca JC, Obadia D. Case for diagnosis erythromelanosis follicularis faciei et colli. An Bras Dermatol. 2010;85:923–5.
2. Errichetti E, Stinco G, Lacarrubba F, Micali G. Dermoscopy of Darier's disease. J Eur Acad Dermatol Venereol. 2016;30:1392–4.
3. Errichetti E, Stinco G. Dermoscopy in general dermatology: a practical overview. Dermatol Ther (Heidelb). 2016;6:471–507.
4. Panchaprateep R, Tanus A, Tosti A. Clinical, dermoscopic, and histopathologic features of body hair disorders. J Am Acad Dermatol. 2015;72:890–900.
5. Errichetti E, Stinco G. Dermoscopy in differential diagnosis of palmar psoriasis and chronic hand eczema. J Dermatol. 2016;43:423–5.
6. Patterson JW. Disease of cutaneous appendages. In: Patterson JW, editor. Weedon's skin pathology. 4th ed. Philadelphia, PA: Elsevier; 2015. p. 499.
7. Luna PC, Abad ME, González VM, Vigovich F, Casas JG, Larralde MAT Erythrosis pigmentosa peribuccalis in an adolescent: dermoscopic description and management. Pediatr Dermatol. 2016;33:e65–8.

Please cite this article in press as: Errichetti E, et al. Dermoscopy of Erythromelanosis Follicularis Faciei et Colli. Actas Dermosifiliogr. 2017. http://dx.doi.org/10.1016/j.ad.2017.04.016

8. Güngör Ş, Topal IO, Göncü EK. Dermoscopic patterns in active and regressive lichen planus and lichen planus variants: a morphological study. Dermatol Pract Concept. 2015;5:45–53.
9. Wang L, Xu AE. Four views of Riehl's melanosis: clinical appearance, dermoscopy, confocal microscopy and histopathology. J Eur Acad Dermatol Venereol. 2014;28:1199–206.
10. Li Y, Liu J, Sun QN. Characteristic dermoscopic features of melasma. Zhongguo Yi Xue Ke Xue Yuan Xue Bao. 2015;37:226–9.

E. Errichetti[a,*], S. Pizzolitto[b], G. Stinco[a]

[a] *Department of Experimental and Clinical Medicine, Institute of Dermatology, University of Udine, Italy*
[b] *Department of Pathology, Santa Maria della Misericordia Hospital, Udine, Italy*

* Corresponding author.
E-mail address: enzoerri@yahoo.it (E. Errichetti).

Please cite this article in press as: Errichetti E, et al. Dermoscopy of Erythromelanosis Follicularis Faciei et Colli. Actas Dermosifiliogr. 2017. http://dx.doi.org/10.1016/j.ad.2017.04.016