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Pale Orange Perifollicular Halo as a Dermatoscopic Sign in Scurvy

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To the Editor:

The cutaneous lesions of scurvy have traditionally been described as disseminated purpura, follicular keratotic papules, and "corkscrew" hair.[1-3] The usual dermatoscopic findings have been described as follicular hyperkeratosis, bleeding, and corkscrew hair.[4] Our patient with chronic scurvy presented peculiar scurvy-related findings in the dermatoscopic examination.

A 68-year-old a man with a history of alcoholism and no teeth, who had been following a diet consisting solely of plain cakes for quite some time, came to the emergency department of our hospital. He presented considerable deterioration in his overall condition from 2 months previously as well as asthenia, anorexia with significant weight loss, and progressive tendency to be bed-ridden, pain and swelling in the right knee, and violaceous cutaneous lesions on the legs and abdomen (Figure 1). His personal history included several episodes of hemarthrosis and flare-ups of hematuria in the previous 2 years that had not been specifically diagnosed. Dermatoscopy of the cutaneous lesions revealed a pale orange perifollicular halo surrounded by another peripheral hemorrhagic violaceous halo, along with "corkscrew" hair and follicular hyperkeratosis (Figure 2). A skin biopsy showed a ringlet-like hair shaft sectioned at different levels inside the follicle, compact perifollicular fibrosis, and extravasated erythrocytes in the dermis, but not in the perifollicular fibrotic area mentioned above (Figure 3).

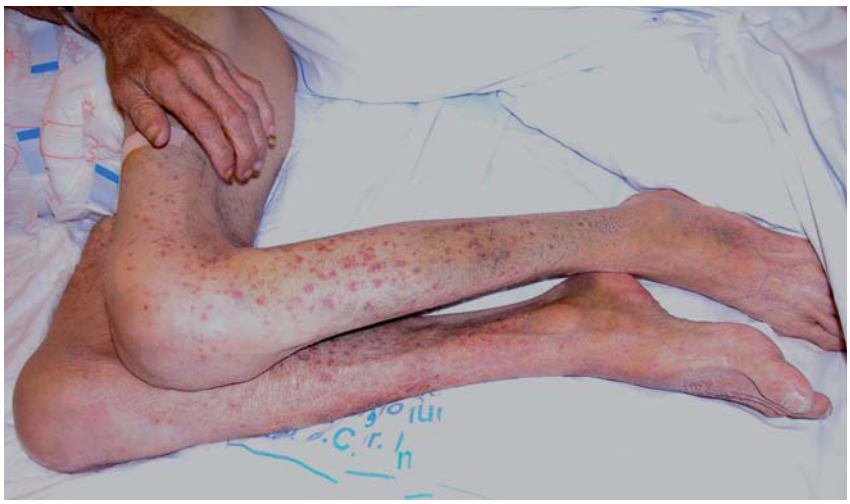

Figure 1. Note the large violaceous lesions, follicular hyperkeratosis, and coiled hairs observed in our patient.

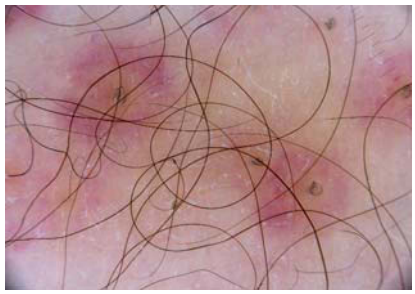

Figure 2. In addition to "corkscrew" hair, the dermatoscopic image showed a pale orange perifollicular halo, surrounded by violaceous lesions.

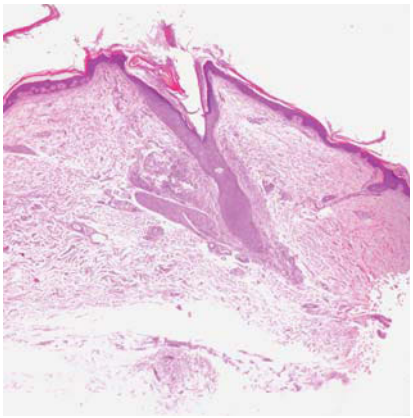

Figure 3. Histopathology revealed perifollicular fibrosis. The extravasated erythrocytes were distributed around the follicle, in areas where the dermis was looser. Note the hair shaft sectioned at different levels inside the follicle (hematoxylin-eosin, ×40).

Because scurvy was suspected, plasma ascorbic acid levels were measured and found to be noticeably low (<0.1 mg/dL; normal range, 0.2-0.4 mg/dL), thereby confirming the diagnosis. The patient responded extremely well to oral treatment with vitamin C and nutritional supplements of fruits and vegetables; the skin lesions disappeared within 15 days and his overall health improved noticeably.

The peculiar pale orange halo observed on dermatoscopy could be explained as the result of the usual changes observed in the violaceous lesions once the extravasated erythrocytes began to be reabsorbed. Such reabsorption might start near the follicle, explaining the presence of the orange halo as a temporary finding within a dynamic process. Against this explanation was the fact that the patient had still not started treatment or experienced clinical improvement as a result. We felt that a correlation between the dermatoscopic image and histopathologic findings was more likely. The perifollicular fibrosis observed in our patient would have rejected or prevented erythrocyte accumulation in the area and both factors (fibrosis and absence of erythrocytes) would explain the pale orange halo mentioned. Beyond the fibrosis area, the dermal collagen would be looser and so allow erythrocytes to accumulate, producing hemorrhagic lesions at the periphery of the pale orange area.

We therefore believe that this dermatoscopic observation is not without importance, but could be correlated with the histopathologic findings. If confirmed, the observation could allow chronic and acute scurvy to be distinguished through a clinical sign. There is no reason why acute scurvy would be associated with such a halo, since the perifollicular fibrosis that determines this dermatoscopic sign would not have developed. However, more observations are needed to confirm the validity of this observation.

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Single Reticulohistiocytoma Mimicking a Keratoacanthoma

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To the Editor:

Reticulohistiocytosis is a rare form of presentation of non-Langerhans cell histiocytosis.[1] It has a broad spectrum of presentation, from a single nodular cutaneous lesion (solitary cutaneous reticulohistiocytosis) or multiple lesions (multiple cutaneous reticulohistiocytosis), to more aggressive forms with multiple lesions and joint involvement (multicentric reticulohistiocytosis), associated with an internal neoplasm in a significant number of patients.[2] We describe the case of a solitary reticulohistiocytoma seen in our department.

A 23-year-old man with no relevant personal or family history came to our dermatology department in February 2007 because of a nodular lesion that had appeared on the lateral aspect of the right third finger 6 months previously; the lesion had been gradually growing and was painful to touch. The examination revealed a dome-shaped nodule of firm consistency, reddish-violaceous and approximately 1 cm in diameter, with a somewhat umbilicated and keratotic center, which resembled a keratoacanthoma (Figure 1). The lesion was removed surgically; the histopathologic study showed a well-