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## Morphea Distributed Along Narrow Blaschko Lines

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### To the Editor:

A 4-year-old girl, with no personal or family history of interest, presented pigmented lesions on the arms and trunk that had appeared approximately 1 year earlier. The initial lesions were papules of normal skin color that progressed to hyperpigmented, slightly raised lesions with a smooth, shiny surface and that were indurated and sclerotic. On examination, the lesions were observed along the length of the left upper limb, following 2 narrow lines from the wrist to the shoulder (Figure 1); this line continued across the left shoulder to the midline of the back. Another similar, linear lesion was found on the left side of the abdomen, following an S-shaped path.

There were no associated cutaneous or systemic symptoms. The complete blood count and biochemistry were normal. Antinuclear antibodies were positive at a titer of 1/160 and the results for perinuclear antineutrophil cytoplasmic antibodies, cytoplasmic antineutrophil cytoplasmic antibodies, and anti-Ro, anti-La, anti-Smith, anti-ribonucleoprotein, anti-Scleroderma DNA Topoisomerase I, and anti-Jo1 antibodies were negative. Histopathological

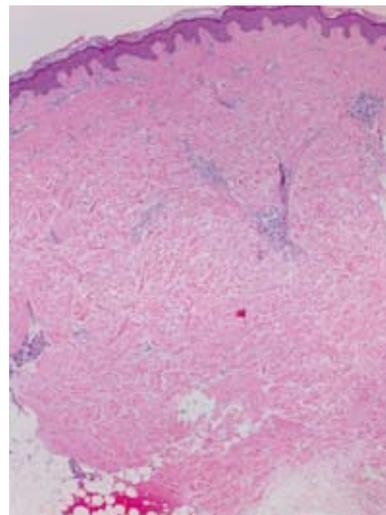
examination revealed a normal epidermis with thickening of the dermis due to the presence of wide, sclerotic bands of collagen, mainly in the middle and deep dermis. In addition, there was a moderate inflammatory infiltrate formed of lymphocytes and a few plasma cells, with a superficial, deep, and perivascular distribution (Figure 2). The skin adnexa appeared atrophic, with no peripheral adipose tissue, and staining with orcein demonstrated preservation of the elastic fibers.

The lesions had been stable since their onset and it was therefore decided to maintain the patient under observation with no treatment.

Linear morphea is a rare disorder that usually occurs in childhood and can affect any area of the body surface. It includes what are considered to be special forms, such as morphea en coup de sabre and progressive facial hemiatrophy. A number of cases of morphea following the Blaschko lines on the trunk and limbs have been reported previously.<sup>1-3</sup> However, frontoparietal morphea en coup de sabre is more clearly limited to the Blaschko lines described.<sup>4</sup> In the case of linear morphea of the



**Figure 1.** Indurated papules grouped along the left upper limb and on the left hemiabdomen.



**Figure 2.** Thickening and sclerosis of the dermal collagen bundles, with a moderate perivascular inflammatory infiltrate formed of lymphocytes and a few plasma cells. Hematoxylin-eosin,  $\times 10$ .

limbs, most cases involve broad Blaschko lines, making it more difficult to recognize a clear mosaic pattern. In our patient, the presence of morphea lesions along 1 limb, following the path of narrow Blaschko lines, supports the origin of linear morphea from cutaneous mosaicism. It is not known why the majority of cases of linear morphea reported are associated with broad Blaschko lines and only a few with narrow Blaschko lines. It may be that cutaneous mosaicism of ectodermal origin tends to follow the narrow lines whilst that of mesodermal origin tends to follow broad lines, although this correlation is not complete.<sup>5</sup> With regard to morphea, it is likely that it is not a single disease but rather a common clinical manifestation of a number of disorders with different etiologies.

As with other patients reported in the literature, the findings in our patient support the hypothesis that linear morphea is, at least in a significant number of cases, the expression of a genetic mosaicism of a disease of probable polygenic origin. The presence of circulating antibodies<sup>6</sup> and the existence of patients with multiple lesions of morphea and who also present linear lesions, supports the concept of mosaicism for linear morphea; those cases probably represent segmental manifestations superimposed on a polygenic disorder. The finding of this condition in patients with other collagen diseases, such as linear lupus erythematosus,<sup>7</sup> is another argument in favor of this hypothesis.

## Dermatologists' Approach to Lesions Suggestive of Onychomycosis of the Toenails

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*To the Editor:*

Onychomycosis of the toenails is a common problem (accounting for more than 50% of all nail disease, with a prevalence in Europe of 26.9%,<sup>1</sup> and close to 50% in the population over 70 years of age). It affects quality of life and is responsible for 1.8 medical consultations per patient every 6 months.<sup>2</sup> The systemic treatment recommended at the present time is safe, and severe adverse reactions are rare.<sup>3,4</sup>

Current clinical guidelines recommend performing direct examination of nail fragments with potassium hydroxide, culture, or biopsy of the nail with pathological study in order to confirm the diagnosis before starting systemic treatment.<sup>5</sup> However, these tests are not as reliable as might be hoped. The 3 tests have a positive predictive value of around 75% and a negative predictive value that

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### Conflicts of Interest

The authors declare no conflicts of interest.

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varies between 67% and 90%.<sup>6,7</sup> Using only these tests, approximately 25% of patients will receive unnecessary treatment and between 10% and 33% of patients will remain untreated, depending on the test used. For this reason, dermatologists sometimes rely more on the clinical signs than on the results obtained in those tests.

Our aim has been to describe the dermatologist's approach to lesions suggestive of onychomycosis of the toenails. For this purpose, on May 31, 2008, we performed an anonymous survey of 68 participants at the meeting of the Galician Section of the Spanish Academy of Dermatology and Venereology (AEDV). More than 95% of dermatologists in Galicia belong to this section of the society. The survey was answered by 51 individuals (44.7% of the members of the section). Mean duration of professional experience was 10 years (interquartile range,