

CASE AND RESEARCH LETTERS

Relieving the Pain Associated with Plantar Warts

¿Se puede mitigar el dolor asociado a las verrugas plantares?

To the Editor:

Plantar warts are caused by cutaneous human papillomavirus.¹ The condition is a very common reason for visits to a dermatologist,²⁻⁴ and, although the warts are totally benign, they are accompanied by significant morbidity, as standing and walking typically cause pain and discomfort.^{5,6}



Figure 1 Insoles with circular cutouts that avoid pressure on a plantar wart.

We describe a simple system for reducing or eliminating the pain associated with plantar warts that might also be useful for other conditions affecting the soles of the feet, such as plantar keratosis.

The solution is as simple as making a hole in the shoe insole (Figure 1), in such a way that the sole remains in contact with the insole except in the area of the wart. Commercially available options, which only include different types of cushioned pads with a central hole (Figure 2), have the same purpose, except that walking, weight-bearing, or perspiration often displace the pad so that it ends up under the wart. This would not happen with the cutout insole, given that it fits exactly inside the shoe and so is held in place. Cases where pain and discomfort persist are usually due to either the cutout being too small (the wart is still in direct contact with the insole) or the insole itself is too thin (a problem that can be overcome by using 2 or 3 insoles together).

In conclusion, an insole with a cutout is a simple and economical system that patients can apply in their own home as an effective solution for relieving the discomfort and pain associated with plantar warts.

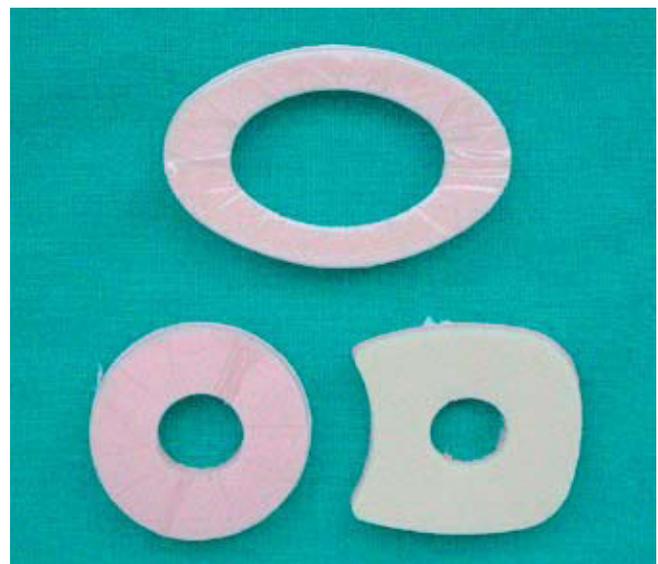


Figure 2 Cushioned pads with holes, available commercially.

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Facial Granulomatous Dermatoses

Dermatitis granulomatosa facial

To the Editor:

The term *facial granulomatous dermatosis* refers to a group of disorders characterized by facial papules with the common histological feature of epithelioid granulomas. We present a patient whose condition fitted this classification both clinically and histologically, and who illustrates well the difficulties experienced when managing this disorder.

The patient was a 64-year-old woman with no family or personal past history of interest. She was seen in 2005 for asymptomatic facial lesions. On physical examination she presented erythematous papules of 1 mm in diameter in the perioral region, with no comedones or pustules (Figure 1). The initial suspicion was of perioral dermatitis and treatment was started with oral doxycycline (100 mg/12 h) for 3 months, with no improvement. A biopsy



Figure 1 Patient with perioral erythematous papules and pustules. There are no comedones.

was therefore performed; in areas close to the hair follicles there were multiple granulomatous structures formed of epithelioid cells with a peripheral lymphocytic infiltrate and central necrosis, compatible with lupus miliaris disseminatus faciei (LMDF). Ziehl-Neelsen stain performed on the histological specimen was negative for acid and alkali-fast bacilli (Figure 2).

Further additional tests, including complete blood count, erythrocyte sedimentation rate, biochemistry, calcium, Mantoux, chest radiograph, and angiotensin-converting enzyme levels, were normal or negative.

The patient was then administered oral prednisone, with a response only at doses higher than 20 mg/d. She did not tolerate minocycline, sulfone, or thalidomide, and, after oral isotretinoin, developed an intense outbreak of lesions that extended to the periocular and malar regions (Figure 3).

Over time, the outbreaks have affected the periocular region, cheeks, and neck, and, in the last year, have been associated with episodes of facial flushing. Some lesions have left pinpoint scars.

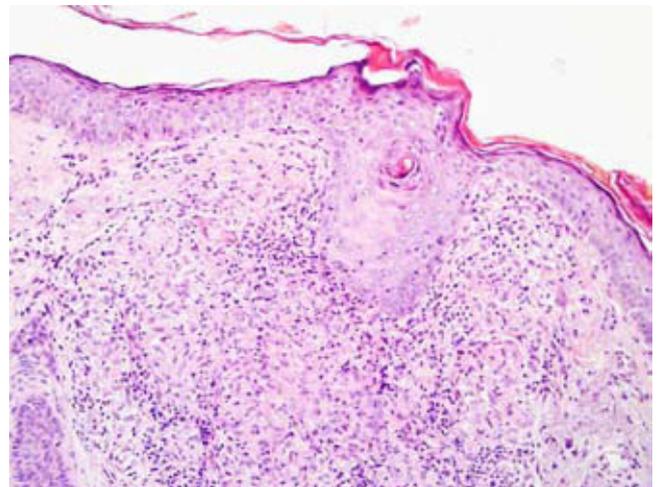


Figure 2 Perifollicular granulomas with epithelioid cells, peripheral lymphocytes, and central necrosis. Hematoxylin-eosin, original magnification $\times 20$.