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https://doi.org/10.1016/j.adengl.2021.10.009

Heterotopic Salivary Gland Tissue☆

Heterotopia salival

To the Editor:

Salivary gland heterotopia or choristoma consists of the presence of salivary gland tissue outside the major and minor salivary glands. It is a rare disease, usually congenital, secondary to the persistence and abnormal development of vestigial structures[1,2].

A 53-year-old woman with no past history of interest reported the appearance in childhood of a nodular lesion in the right lower anterior cervical region that had been growing slowly and gradually. The lesion occasionally exuded a clear, odorless liquid, frequently in association with eating. The examination revealed a soft nodule measuring 9 mm in diameter, with overlying light-brown skin, located on the right sternoclavicular joint. It was associated with a small central orifice with no active draining on pressing (Fig. 1A and B). Ultrasound revealed a well-defined nonencapsulated hypoechoic subcutaneous lesion with no clear fistular tracts and with no vascularization in the Doppler study (Fig. 2). The

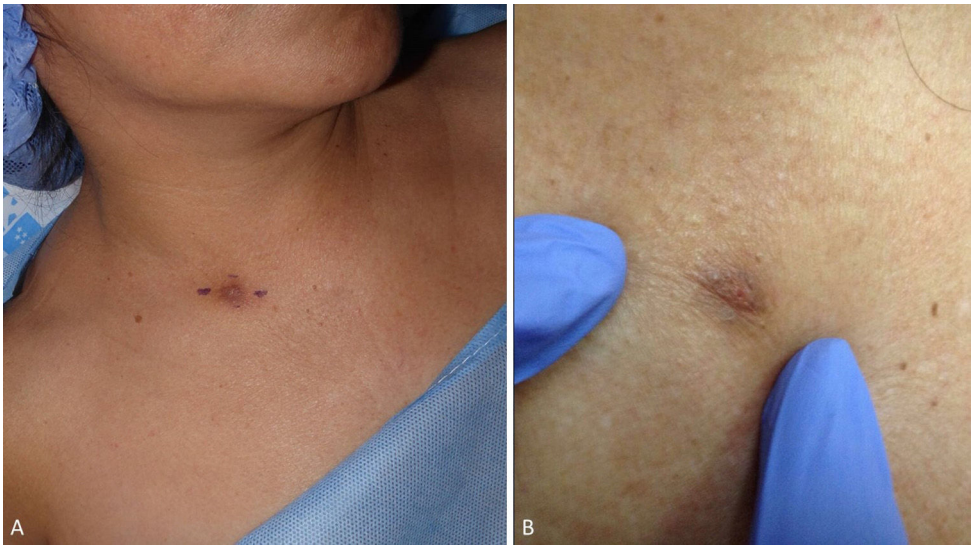

Figure 1 Right supraclavicular nodular lesion.

☆ Please cite this article as: Chicharro P, Rodríguez-Jiménez P, Fraga J, Llamas-Velasco M. Heterotopia salival. Actas Dermosifiliogr. 2021;112:949–951.

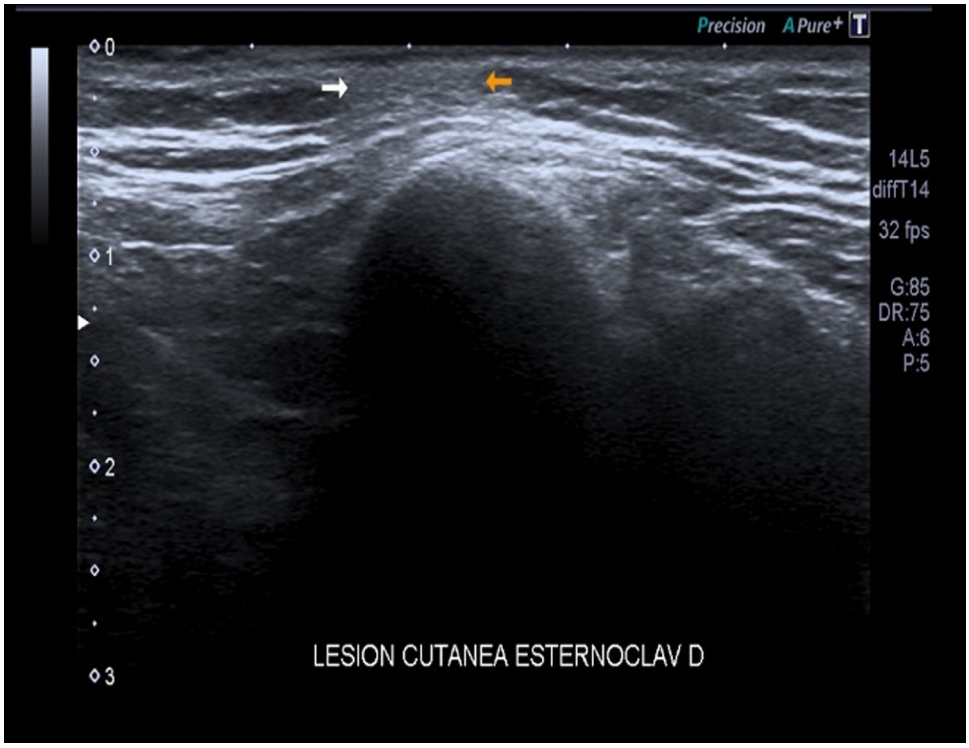

Figure 2 Ultrasound study with well-defined nonencapsulated, hypoechoic subcutaneous lesion.

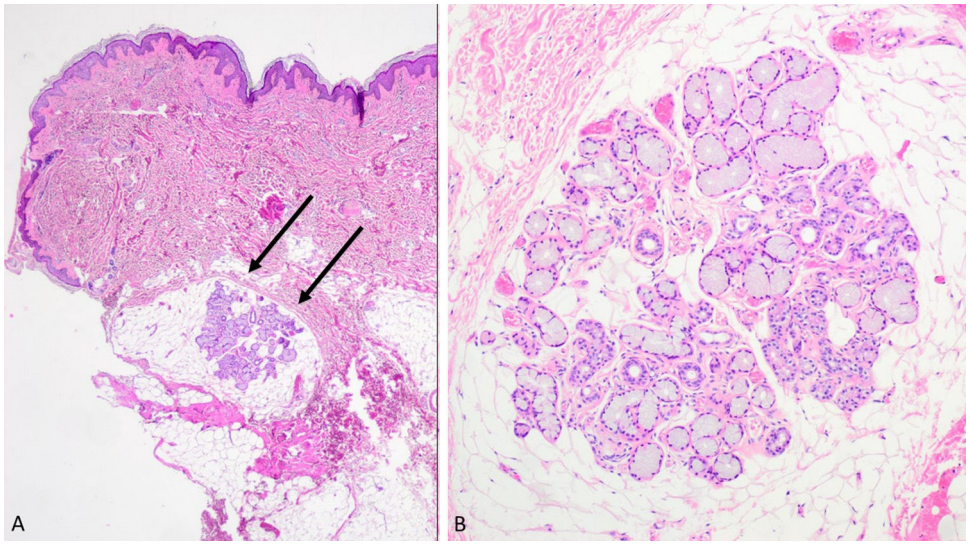

Figure 3 In subcutaneous cellular tissue, aggregates of salivary gland tissue made up of mucous and serous glands.

lesion was excised and the histopathology study revealed aggregates of salivary gland tissue made up of mucous and serous glands, accompanied by a discrete ductal excretory component, located in the subcutaneous cell tissue (Fig. 3A,B). It presented isolated foci of lymphocytic inflammatory infiltrate. These findings led to a diagnosis of salivary gland heterotopia. The patient remained asymptomatic during follow-up, with no signs of recurrence.

Salivary gland heterotopia is a rare disease, associated with abnormal development of the branchial apparatus, and only small series or isolated cases have been reported in the literature. The pathogenesis is unknown but the most widely accepted hypothesis suggests that it is due to defective closure of the precervical sinus within the branchial apparatus. It usually manifests at birth or in early childhood as a nodular, cystic, or fistulized lesion that is asymptomatic except for the occasional secretion of a fluid similar to saliva, predominantly located on the lower anterior part of the sternocleidomastoid muscle, with a predilection for the right side[1,2]. Other reported locations are the mandibular region,

the middle ear, the sella turcica, the parathyroid glands, the mediastinum, and the rectum[3–8]. Although rare, bilateral presentation is also possible[2]. Histology shows mucous and/or serous salivary gland structures, often with an associated ductal component (dilated, collapsed, or absent) and chronic periductal inflammation. Its association with other congenital anomalies is very rare[2].

Surgical treatment is indicated for diagnostic purposes and to prevent inflammatory processes and potential neoplastic degeneration. In fact, in the largest series available in the literature, with 24 cases of salivary gland heterotopia, associated malignant tumors were found in 6 cases (3 mucoepidermoid tumors, 2 acinar cell carcinomas, and 1 adenocarcinoma)[9]. While malignancy in a heterotopic area must be considered in cases of salivary gland carcinoma outside the salivary glands, metastatic dissemination should also be ruled out[2,9,10]. While no data exist in the literature, ultrasound may be particularly useful in the differential diagnosis with other more common diseases and in preoperative planning. Based on our case and the literature, in the event of a nodular lesion in a typical location, with secretion and with ultrasound showing no characteristics of a cystic lesion, we must include salivary gland heterotopia in the differential diagnosis.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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https://doi.org/10.1016/j.adengl.2020.02.002

Comet Sign in Dermatitis Due to *Pyemotes* Species☆

Signo de la cometa en la dermatitis por *Pyemotes*

To the Editor:

The presence of linear or serpiginous tracks is a characteristic cutaneous sign of certain parasitic conditions. Although autochthonous cases of cutaneous larva migrans have been described in Spain, most cases are diagnosed in travelers from tropical regions.[1] However, in patients who have not traveled to tropical areas this finding entails a broader differential diagnosis, which should include comet sign. We describe the presence of this clinical sign in 2 adult patients with dermatitis caused by *Pyemotes* species.

A 25-year-old woman with no relevant dermatological history consulted in May due to the presence of pruritic lesions on the legs that had appeared 72 hours earlier. She had no extracutaneous signs and had not applied any topical preparations. Physical examination revealed several polygonal macules, from which painless erythematous tracks originated (Fig. 1). The patient reported having spent several hours in a rural accommodation in Segovia that was rarely visited during the rest of the year. Most of the furniture was wooden and the patient had noticed small holes in the wood accompanied by sawdust, signs of woodworm infestation. Dermoscopy revealed a microvesicle at the center of each polygonal macule (Fig. 2). Skin biopsy showed a dermal infiltrate composed of eosinophils and lymphocytes. No epidermal changes were evident. Betamethasone cream was indicated as a symptomatic treatment, and resulted in lesion resolution after 72 hours (Fig. 3).

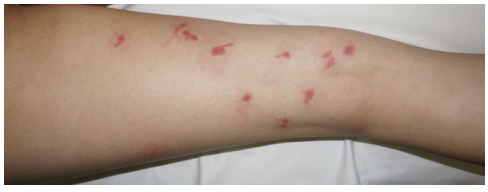

Figure 1 Multiple lesions exhibiting the comet sign on the leg of Patient 1.

☆ Please cite this article as: Pulido Pérez A, Bergón-Sendín M, Hernández-Aragüés I, Suárez-Fernández R. Signo de la cometa en la dermatitis por *Pyemotes*. Actas Dermosifiliogr. 2021;112:951–952.