

Usefulness of Dermoscopy in Plantar Pilonidal Sinus[☆]

Sinus piloso plantar. Utilidad de la dermatoscopia

To the Editor:

Dermoscopy has been incorporated as a useful dermatologic diagnostic tool in recent years. Its original indication—the differential diagnosis of pigmented lesions—has been broadened to include other noncancerous skin diseases, such as diseases of the hair,¹ psoriasis, scabies,² and connective tissue diseases.³ We report a case in which dermoscopy was used to rule out a pigmented plantar lesion.

A 67-year-old woman was referred to our department for the diagnosis of a presumed pigmented lesion on the sole of her right foot. The primary care physician suspected melanoma. The patient did not relate it to any injury and explained that the lesion had appeared over the previous month. She denied any preexisting pigmented lesion at this site.

On inspection, there was a macule of uneven pale brown color, with a diameter of 3 mm. The type of lesion was not readily diagnosed with the naked eye (Fig. 1).

We examined the lesion with a digital dermatoscope (MoleMax III, Derma Medical Systems, Vienna, Austria) (Fig. 2). A coiled hair shaft was observed below a normal stratum corneum, simulating an accumulation of pigment. This finding led to a diagnosis of pilonidal sinus. Scraping of the stratum corneum with a #11 scalpel blade allowed the hair to be removed. We explained the harmless, benign nature of the plantar lesion to the patient. When asked about her habits, she denied working as a hair stylist. Hence, it was assumed that the hair had become embedded in the stratum corneum accidentally.

Pilonidal sinus or “barber’s sinus”⁴ is a well-known occupational skin disease that tends to affect hairdressers or barbers. These professionals can experience penetration of hairs under their skin. An inflammatory response and a foreign body granuloma often develop. The most common site for this disorder is the interdigital spaces of the hands, although cases on the soles of the feet have also been described.⁵ No inflammatory response was observed in our patient. Hence, the condition resembled coiling hairs that grow below the stratum corneum on the legs of some women after waxing or shaving. Confusion of pilonidal sinus with other processes is not uncommon, and there has even been a report of a case of a coiled hair below the stratum corneum of the pubic skin simulating a larva migrans.⁶

Dermoscopy was useful in this case and prevented unnecessary surgical removal of the lesion.



Figure 1 Clinical image of the lesion: pigmented macule on the sole of the foot.



Figure 2 Dermoscopy image: hairy shaft below the stratum corneum.

References

1. Tosti A, Torres F. Dermoscopy in the diagnosis of hair and scalp disorders. *Actas Dermosifiliogr.* 2009;100:114–9.
2. Levitt JO. Digital photography in the diagnosis of scabies. *J Am Acad Dermatol.* 2007;56:53–62.
3. Tosti A, Torres F, Misciali C, Vincenzi C, Starace M, Miteva M, et al. Follicular red dots: a novel dermoscopic pattern

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observed in scalp discoid lupus erythematosus. Arch Dermatol. 2009;145:1406–9.

4. Uysal AC, Alagöz MS, Onlü RE, Sensöz O. Hairdresser's syndrome: a case report of an interdigital pilonidal sinus and review of the literature. Dermatol Surg. 2003;29:288–90.
5. Morrell JF. "Pilonidal" sinus of the sole. Arch Dermatol. 1957;75:269.
6. Sakai R, Higashi K, Otha M, Sugimoto Y, Ikoma Y, Horiguchi Y. Creeping air: an isolated hair burrowing in the uppermost dermis resembling larva migrans. Dermatology. 2006;213:179–81.

J. Romani,* M. Sábat, L. Leal, J. Luelmo

Servicio de Dermatología, Hospital Parc Taulí, Sabadell, Universitat Autònoma de Barcelona, Barcelona, Spain

* Corresponding author.

E-mail address: jromani@tauli.cat (J. Romani).

Extramammary Paget Disease Treated With 5% Imiquimod Cream[☆]

Enfermedad de Paget extramamaria tratada con imiquimod 5% crema

To the Editor:

Extramammary Paget disease (EMPD) is a rare cutaneous neoplasm. It is an intraepithelial adenocarcinoma that develops in areas rich in apocrine glands.¹ The most commonly affected site is the vulva, followed by, in order of frequency, the scrotum, the perianal region, and the axillas.² It is essential to screen for other tumors as EMPD is associated with malignancy at other sites.

A higher prevalence of the disease has been observed in white women aged between 50 and 80 years; because its clinical presentation is variable and nonspecific, EMPD is often confused with dermatitis, leading to delayed diagnosis and treatment.¹

The traditional treatment of choice is surgical excision with wide margins, but even so, the disease has a high rate of recurrence (up to 43%).¹

We describe the case of a 72-year-old woman, with no past history of interest, who consulted for a skin lesion with an eczematous appearance that had appeared on the vulva over a year earlier. Physical examination revealed a scaly erythematous plaque measuring 8 x 5 cm containing whitish islands alongside eroded, exudative areas (Fig. 1). The patient said that she had been treated, without success, with topical corticosteroids, antibiotics, and antifungals for months.

We performed a biopsy of the lesion to confirm the suspected diagnosis of EMPD. Histology showed hyperkeratosis, parakeratosis, acanthosis, and diffuse infiltration by cells with abundant pale cytoplasm and vacuolated nuclei (Paget cells) throughout the epidermis. There was no evidence of dermal infiltration. Immunohistochemistry was positive for carcinoembryonic antigen, epithelial membrane antigen, cytokeratin (CK) 7, and CK18 (Fig. 2).

On confirming the diagnosis of EMPD, we searched for associated malignancy, but the results were negative.

Because of the considerable functional and cosmetic sequelae associated with the surgical treatment of EMPD, we analyzed alternative treatments and opted for 5% imiquimod cream. The patient consented to treatment after having been informed of the good results achieved in cases similar to hers, as well as of the disadvantages associated with this therapy. After cleaning of the area, the cream was applied to the lesion and to 1 to 2 cm of healthy skin around the lesion. Treatment was administered nightly 6 days a week. The patient tolerated the treatment well, despite the initial appearance of erosions and small crusts on the affected area. These lesions did not require interruption of the treatment. The patient was advised to apply fusidic acid ointment to the lesion to prevent superinfection and to help loosen the small crusts. Clinical resolution of the lesion was observed after 6 weeks of treatment (Fig. 3), but the patient was advised to continue treatment up to week 16. After this, the frequency of treatment was reduced to 3 times a week, with monthly outpatient follow-up in the dermatology department up to week 24. A skin biopsy performed several months later confirmed resolution of the disease and confirmed the absence of tumor cells. Once-weekly topical imiquimod was prescribed as maintenance therapy.³

At the time of writing, after 14 months of follow-up, there were no signs of recurrence.



Figure 1 Scaly erythematous plaque containing whitish islands alongside eroded, exudative areas on the vulva.

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