



Figure 3 Second bout of type I pityriasis rubra pilaris. Large patches of scarring alopecia with follicular flaking and patchy perifollicular erythema that developed into atrophic pearly patches without erythema or scaling.

cia might have been induced by the follicular involvement characteristic of PRP.

Although fine scaling of the scalp and face is frequent in type I PRP,² and is sometimes accompanied by non-scarring alopecia,⁴ an association of type I PRP with scarring alopecia has not been described before. In 1968, Bergeron and Stone⁵ reported the case of a patient with PRP who developed acne conglobata, hidradenitis suppurativa, and dissecting cellulitis of the scalp. Acitretin-induced scarring alopecia has never before been reported,⁶ and in any case, our patient was no longer taking acitretin at the onset of the second bout and of scarring alopecia. The follicular hyperkeratosis and perifollicular erythema of the scalp present during both bouts of type I PRP could have disturbed our patient's hair follicles enough to trigger fulminant scarring alopecia.

The clinical appearance of our patient's scarring alopecia is reminiscent of pseudopelade of Brocq in large, scattered patches. It is unclear whether pseudopelade is a disease in

itself or the final stage of other, primary forms of scarring alopecia. In the initial stage, our patient's condition resembled lichen planopilaris or cutaneous lupus erythematosus. Nevertheless, the absence of any perifollicular lymphocytic inflammatory infiltrate, the replacement of hair follicles with dermal fibrosis, and the negative direct immunofluorescence test results make lichen, lupus, and pseudopelade unlikely diagnoses.

We therefore consider this to be a case of scarring alopecia of an unusually fulminant course and severity associated with a bout of type I PRP, and with histologic findings that rule out a primary classic form of scarring alopecia. The alopecia underwent rapid clinical transformation into generalized pseudopelade in large patches, but the only histologic finding was fibrosis.

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Penile Paraffinoma[☆]



Parafinoma de pene

Penile paraffinoma is a skin reaction that develops after the injection of paraffin or mineral oil into the penis in order to increase its size. The condition is relatively common in some eastern European and Asian countries and we believe immigration will cause its frequency in Spain to rise. The procedure is usually performed by nonmedically

qualified persons and under poor hygienic conditions. The skin reaction to the exogenous material typically develops months or years after the injection.¹

We present the case of a 27-year-old man from Romania who consulted for ulcerated lesions on the penis. Although the patient initially omitted the fact, he later stated that for the previous 4 years until 2 months prior to consultation he had undergone repeated injections of a viscous material into the shaft of the penis in order to increase its size. He also stated that progressively enlarging ulcerated lesions had appeared on the penis and that they had worsened in appearance over the previous months. He had therefore

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Figure 1 Ulcerated lesion of about 3 cm diameter on the right lateral surface of the penile shaft.

applied the contents of oral antibiotic capsules to the area, but with no improvement. On physical examination there was a marked deformity of the shaft of the penis, which was indurated on palpation, and there were 2 ulcerated lesions with maximum diameters of 3 and 2 cm, respectively, located on the lateral surfaces of the penis (Fig. 1). Fistulous tracts were present on the ventral surface, with no visible secretion. The glans was not affected. Histopathology of the larger lesion showed an epithelial ulcer with dermal fibrosis and empty vacuoles, consistent with paraffinoma (Figs. 2 and 3). Staining with periodic acid-Schiff, silver methenamine, and Ziehl-Neelsen was negative. Blood tests were normal and a swab from the ulcers isolated a large number of different colonies, with no predominant microorganism. Culture for fungi was negative. Serology was negative for hepatitis C and human immunodeficiency virus and positive for hepatitis B, herpes simplex virus type 1, herpes simplex virus type 2, and syphilis (VDRL titer 1:2; TPHA, 1:10 240). The patient was diagnosed with penile paraffinoma, and topical therapy was applied with potassium permanganate poultices. The lesions showed some improvement, and the necrotic areas healed. However, after offering the patient surgical reconstruction, he

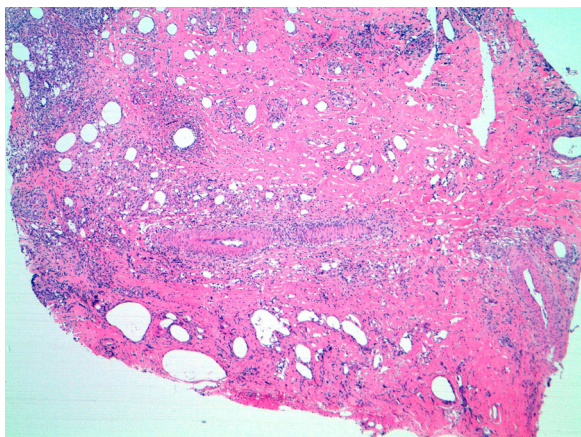


Figure 2 Photomicrograph showing fibrosis in the papillary and reticular dermis, in addition to multiple empty vacuoles that had contained the paraffin. Hematoxylin and eosin, original magnification $\times 4$.

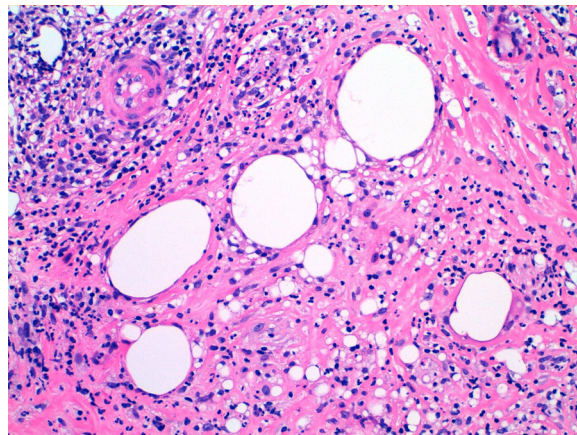


Figure 3 Photomicrograph showing the empty vacuoles at greater magnification. The histiocytes are also seen in greater detail and some multinucleated giant cells are present due to the foreign body reaction. Hematoxylin and eosin, original magnification $\times 20$.

stopped coming to the visits, and we were therefore unable to repeat the serology and we considered the syphilis cured.

Penile paraffinoma is also known as sclerosing lipogranuloma of the penis. The most common etiology of this condition is the injection of highly viscous materials, such as mineral oils, petrolatum, or paraffin, and this is still being performed in eastern Europe, Asia, and Russia.² The practice was first performed, however, in 1899 by an Austrian surgeon called Robert Gersuny, who injected mineral oils into a child after orchiectomy for genital tuberculosis.¹ The motivation for patients to undergo this intervention include a desire to increase the size of the penis, to treat erectile dysfunction, and to satisfy their sexual partners.³

The mean age of affected patients is around 28 years, and symptoms typically develop a year after implantation of the material. Clinical manifestations usually consist of deformity, impotence, erythema, and edema leading to paraphimosis and pain. The main complications are infection, ulceration, necrosis, and the formation of fistulas.⁴ There have also been reports of migration of the material, with invasion of the corpora cavernosa⁵ and regional lymphadenitis.⁶

As stated above, histology shows multiple pseudocystic spaces associated with signs of a foreign body reaction. This response is almost always present, as the human body has no enzymes that metabolize mineral oils.

The differential diagnosis should include infectious diseases, both sexually transmitted and others, and it is usually therefore necessary to biopsy the lesion and take samples for culture and serology. Diseases such as lupus vulgaris and atypical mycobacterial infection secondary to the injection of sterile material must be excluded. Squamous cell carcinoma must be considered in the case of ulcerated lesions with hard serpiginous borders. A history of injec-

tion of paraffin into the penis is the key to clinical diagnosis.

First-line treatment consists of early complete surgical excision of the foreign body and of the associated reaction, with closure by first intention when possible.⁷ Antiseptics and antibiotics will only treat secondary infections of the lesions. Cases with a good response to systemic corticosteroid therapy have been reported.³

Penile paraffinoma is a condition with an increasing incidence in Spain due to the rise in the number of patients from eastern European and Asian countries. As patients usually deny having had these injections, dermatologists and urologists must suspect this diagnosis when examining genital ulcers that do not correlate with other diseases.

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