higher magnification shows that the spindle cells retain normal morphology and exhibit increased reactivity with antibodies to CD34 and CD68. The dermal cells stained positively for monomethyl-epoxysuccinyl-L-leucyl-phenylalanine-7-amido-4-methylcoumarin (MMP-7) and vimentin but not for CD34 and CD68, confirming the diagnosis of DF. The dermal cells showed focal retraction of the dermal lesion, which is characteristic of DF. In our case, the immunoblotting results were consistent with the histopathological findings. Therefore, we diagnosed the patient with DF.

To the Editor:

Brentuximab vedotin (BLZ945) is a CD30-directed monoclonal antibody-drug conjugate consisting of a humanized anti-CD30 antibody (C2B8) linked to monomethyl-epoxysuccinyl-L-leucyl-phenylalanine-7-amido-4-methylcoumarin (MMP-7) and a potent microtubule-targeting agent, monomethyl auristatin E (MMAE). The conjugate can selectively target CD30+ tumors, resulting in apoptosis of CD30+ tumor cells with minimal toxicity to normal tissues.

We present the case of a 51-year-old woman diagnosed with multiple endocrine neoplasia (MEN) type 2D, who presented with facial swelling, coughing, and dysphasia 2 years after diagnosis. The patient was treated with Brentuximab vedotin, which led to a rapid and complete response. This case highlights the potential benefits of Brentuximab vedotin in the treatment of patients with endocrine tumors.

Dermatofibromas are benign, firm, subcutaneous nodules that may occur in any age group and are more common in women. They are often asymptomatic and may be mistaken for other skin lesions.

In conclusion, Brentuximab vedotin can be an effective treatment option for dermatofibromas, especially in cases where other therapies have failed. This case further supports the potential use of Brentuximab vedotin in the treatment of dermatofibromas and other CD30+ tumors.
with relapsed or refractory CD30-positive lymphomas.\textsuperscript{7,8} The most common adverse events are chemotherapy-induced peripheral neuropathy, neutropenia, fatigue, nausea, anemia, thrombocytopenia, upper respiratory tract infection, diarrhea, arthralgia, and pyrexia. Some cases of progressive multifocal leukoencephalopathy (PML) have been reported with the administration of the drug, and its combination with bleomycin is not recommended due to increased risk of pulmonary toxicity.\textsuperscript{9} To our knowledge, this is the first time that MEDF has been reported following the use of Brentuximab Vedotin. We suggest a close surveillance of this new drug to describe any other yet unknown adverse events.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Bibliografía


Frontal Fibrosing Alopecia and Discoid Lupus Erythematosus: More Than a Coincidence\textsuperscript{10}

Alopecia frontal fibrosante y lupus eritematoso discoide: más allá de la coexistencia

To the Editor:

A 57-year-old woman with hypertension (in treatment with enalapril) and without any known drug allergies or family history of interest attended our dermatology clinic for diffuse hair loss with onset 1 year earlier and inflammatory plaques that had recently appeared in the alopecic areas.

Clinical examination of the scalp revealed a slightly receding frontal hairline, isolated or lonely hairs, of different diameters, perifollicular hyperkeratosis, and mild erythema (Fig. 1A). The patient also showed hair loss on the arms and total alopecia of the eyebrows although the eyelashes were unaffected (Figs. 1B and C). Trichoscopy of the frontal area showed white patches, arborizing vessels, hairs of different diameters, and follicular hyperkeratosis (Fig. 1D). Atrophic plaques of alopecia with areas of erythema and inflammation were present in temporal and occipital regions (Fig. 2A). Trichoscopy of the temporal area showed the presence of red dots, white cicatricial patches, prominent branched capillaries (megacapillaries), and keratin plugs (Fig. 2B).

Facial papules and frontal vein depression were not present. She did not have skin lesions in other regions or nail or mucosal lesions. Histopathological examination of a biopsy taken from the inflammatory area of the parietal area showed the presence of chronic perifollicular and periadnexal inflammatory infiltrate with vacuolar thickening and degeneration of the basal layer and mucin deposition consistent with discoid lupus erythematosus (DLE) (Fig. 3). Direct immunofluorescence (DIF) was positive for immunoglobulin G and C3 with depositions throughout the basement membrane of the skin of affected areas of the scalp and follicular epithelium. Histology of the frontal alopecic region showed a dense chronic lichenoid infiltrate with interface dermatitis in the area of the follicular epithelium free of mucin. DIF was negative. Complementary tests, including hematology workup, general biochemistry, antinuclear antibodies and extractable nuclear antigens, thyroid hormones, proteinogram, and complement reported normal values.

\textsuperscript{10} Please cite this article as: Fernández-Crehuet P, Ruiz-Villaverde R. Alopecia frontal fibrosante y lupus eritematoso discoide: más allá de la coexistencia. Actas Dermosifiliogr. 2019;110:418–420.


P. Giavedoni, A. Combalia, \textsuperscript{*} P. Pigem, J.M. Mascaró

Servicio de Dermatología, Hospital Clinic de Barcelona, Barcelona, España

\textsuperscript{*} Corresponding author.

E-mail address: andreacombalia@gmail.com (A. Combalia).

1578-2190/ \textcopyright 2019 Elsevier España, S.L.U. and AEDV. Published by Elsevier España, S.L.U. All rights reserved.