Dermal collagen bundles (2b, H&E stain, x 200).

Higher magnification shows that the spindle cells are normal and with overlapping epithelial remnants (2a, H&E stain, x 40). Staining a circular pattern of spindle cells in the der-}

showing a circumferential growth pattern in the dermis. H&E bundles of dermal cells (magnification 400x).

Figure 2. Multiple dermatofibromas. Histologic examination showed the presence of spindle-shaped cells resembling fibrohistiocytic cells (hematoxylin and eosin, original magnification, 400x). The dermal collagen bundles are circumferentially arranged, appearing as a circular pattern of spindle cells (2b, H&E stain, x 200).

Antibodies to CD30 and CD68 were used to confirm the presence of CD30-positive cells in the dermis. Immunohistochemical staining revealed the presence of CD30-positive cells in the dermis, along with CD68-positive histiocytic cells. The presence of CD30-positive cells in the dermis was confirmed by immunohistochemical staining.

Figure 3. Immunohistochemical staining for CD30 and CD68. CD30-positive cells (brown color) were present in the dermis, along with CD68-positive histiocytic cells (blue color). Immunohistochemical staining revealed the presence of CD30-positive cells in the dermis.
with relapsed or refractory CD30-positive lymphomas. 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. 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**


P. Giavedoni, A. Combalia,* R. Pigem, J.M. Mascaró

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

*Corresponding author.

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

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

**Frontal Fibrosing Alopecia and Discoid Lupus Erythematosus: More Than a Coincidence**

**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 cicatrical 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.