The lesions usually increase in size and number during the first months and years of life, but gradually diminish without leaving sequelae within a mean period of 11 years after appearance.[3] Although the follow-up of 7 patients was limited to 9 to 18 months, 2 patients (Patients 2 and 8) showed a decrease in lesion size and number during this time.

Familiarity with this entity is important given that hypopigmented lesions are common in pediatric patients. The main differential diagnosis is postinflammatory hypopigmentation. Other clinical diagnoses to consider include pityriasis versicolor, flat warts, and vitiligo.

This is the first reported series of CCP cases in Latin America. Identification of this rare entity in children is important to avoid erroneous diagnoses and unnecessary treatments.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

References

1. Kuo TT, Chan HL, Hsueh S. Clear cell papulosis of the skin. A new entity with histogenetic implications for cutaneous Paget's disease. Am J Surg Pathol. 1987;11:827–34.
2. Wang D, Ho MS, Koh MJ, Giam YC. A case report of clear cell papulosis and a review of the literature. Ann Acad Med Singapore. 2017;46:160–6.
3. Tseng FW, Kuo TT, Lu PH, Chan HL, Chan MJ, Hui RC. Long-term follow-up study of clear cell papulosis. J Am Acad Dermatol. 2010;63:266–73.
4. Kim SW, Roh J, Park CS. Clear cell papulosis: A case report. J Pathol Transl Med. 2016;50:401–3.
5. Kim YC, Mehregan DA, Bang D. Clear cell papulosis: An immunohistochemical study to determine hystogenesis. J Cutan Pathol. 2002;29:11–4.
6. Benouni S, Kos L, Ruggeri SY, North PE, Drolet BA. Clear cell papulosis in Hispanic siblings. Arch Dermatol. 2007;143:358–60.
7. Gianotti R, Cambiaghi S, Locatelli A, Gelmetti C. Clear cell papulosis (pagetoid papulosis) in a non-Asian patient. Dermatology. 2001;203:260–1.
8. Bisi Dos Santos JE, Ribeiro de Miranda MF. Clear cell papulosis: Report of a case with unique clinical and histologic findings. Am J Dermatopathol. 2016;38:924–6.
9. Mohanty SK, Arora R, Kakkar N, Kumar B. Clear cell papulosis of the skin. Ann Diagn Pathol. 2002;6:385–8.
10. Wysong A, Sundram U, Benjamin L. Clear-cell papulosis: A rare entity that may be misconstrued pathologically as normal skin. Pediatr Dermatol. 2012;29:195–8.

C. Apagüeño,[a,*] R. Pomar,[a] J. Peceros,[a] F. Velásquez,[a] R. Ballona,[a] R. Castro,[b] R. Lipa,[c] C. Chian,[d] R. Cano,[e] M. Larralde[e]

[a] *Servicio de Dermatología Pediátrica, Instituto Nacional de Salud del Niño, Breña, Lima, Perú*
[b] *Servicio de Dermatología Pediátrica, Instituto Nacional de Salud del Niño, San Borja, Lima, Perú*
[c] *Servicio de Anatomía Patológica, Instituto Nacional de Salud del Niño, San Borja, Lima, Perú*
[d] *Servicio de Anatomía Patológica, Hospital Nacional Arzobispo Loayza, Lima, Perú*
[e] *Servicio de Dermatología Pediátrica, Hospital Ramos Mejía, Buenos Aires, Argentina*

* Corresponding author.
E-mail address: consuelodejesus111@hotmail.com (C. Apagüeño).

1578-2190/

Ultrasound Characteristics of Lipoma of the Tongue☆

Características ecográficas de los lipomas linguales

To the Editor:

A 60-year-old man with a history of non-insulin-dependent diabetes mellitus and dyslipidemia consulted us for an asymptomatic lesion on his tongue. He reported that it had been present for approximately 2 years, growing at first but then becoming stable over the past few months.

Physical examination showed a rounded well-defined nodule on the right side of the anterior third portion of the tongue. The yellowish nodule measured approximately 6 mm at the longest axis, was reddish on the surface, flexible to the touch, and not adherent to deep layers. Dermatologic ultrasound with an 18 MHz probe showed an oval tumor that was slightly more hypoechoic than the adjacent tissues. The well-defined but not encapsulated tumor measured 7.5 × 2.5 mm on ultrasound and had no Doppler flow either on the surface or at the center. Fig. 1 shows the full length of the nodule. Suspecting a benign, avascular tumor, we performed a 4-mm punch biopsy. The histopathologic

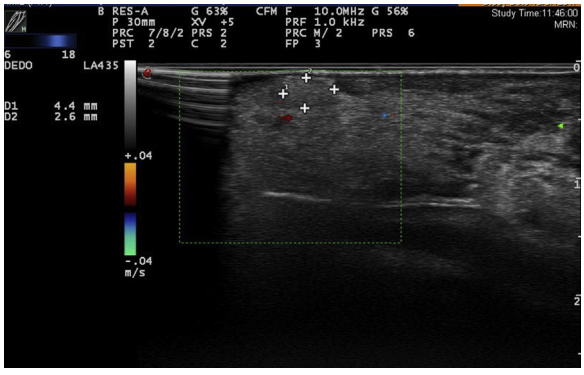

Figure 1 Ultrasound image of the full length of the lesion.

☆ Please cite this article as: Ruiz-Rivero J, Echeverría-García B, Tardío JC, Borbujo J. Características ecográficas de los lipomas linguales. Actas Dermosifiliogr. 2019;110:405–407.

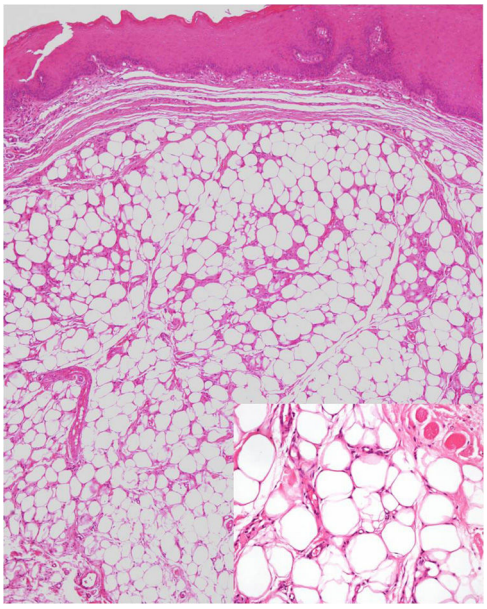

Figure 2 Histologic appearance (hematoxylin-eosin stain, original magnification, ×200; inset ×400).

findings showed a proliferation of mature adipocytes distributed in small lobules separated by thin fibrous septa surrounded by normal stroma (Fig. 2). Our diagnosis based on these findings was lipoma of the tongue.

After the biopsy, 2.5 mm of the lesion remained (Fig. 3). As the lesion was benign and asymptomatic, we were guided by the patient's preference and chose to wait and watch for changes.

Lipomas are benign neoplasms composed of mature adipocytes that are often found on the arms, legs, trunk and even the face. Lipomas inside the mouth, however, are exceptional, accounting for hardly 1% to 4% of benign lesions. The tongue is the most common oral location, accounting for around 30% in the mouth, and most tongue lipomas occur in the anterior third of the structure and on the side. Other more unusual locations are the buccal mucosa, the lips, or the palate.[1,2]

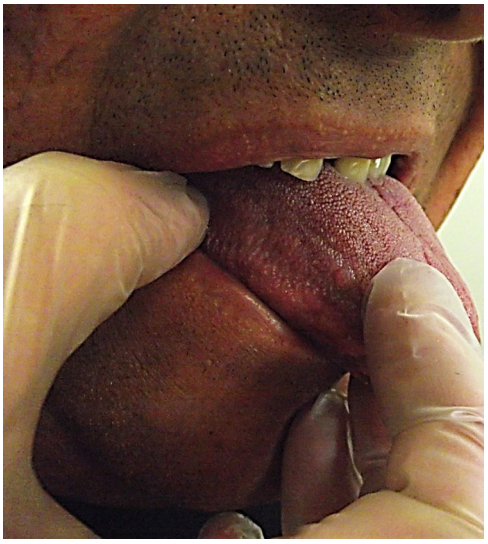

Figure 3 Clinical appearance of the tumor after biopsy.

Lipomas usually present after the age of 40 years as solitary, well-defined, spherical lesions that do not adhere to base layers. They can be yellowish, especially if superficial. Rarely do they cause symptoms other than local irritation or, if they grow large, problems with chewing; however, these oral lesions rarely exceed 2 cm^3.

Differential diagnoses should include other lesions of the tongue, such as mucoceles, fibromas, dermoid cysts, salivary

Table 1 Principal Ultrasound Findings in the Most Common Tongue Lesions

Lesion	Morphology	Ultrasound Characteristics	Compressibility	Doppler Flow
Lipoma	Round or oval, well defined	Hypoechoic; on occasion, short parallel hyperechoic bands	Yes	Absent, scant
Cyst	Round or oval, well defined	Encapsulated, anechoic, posterior enhancement	Partial	No
Neurofibroma	Oval, well defined	Hypoechoic and heteroechoic; on occasion, posterior enhancement	No	May have an augmented center and/or perimeter
Lymphangioma	Oval, well defined	Encapsulated, alternating anechoic and hypoechoic areas separated by hyperechoic septa	Yes	Scant
Hemangioma	Irregular, well defined	Hyperechoic, alternating anechoic and hypoechoic areas separated by hyperechoic septa; on occasion, hyperechoic calcifications with slight posterior acoustic enhancement	Yes	Anechoic spaces, which fill on Doppler imaging
Pyogenic granuloma	Irregular, poorly defined, not encapsulated	Hypoechoic and heteroechoic; on occasion, posterior enhancement	No or partial	Augmented

gland tumors, lymphangiomas, hemangiomas, neuromas, neurofibromas, schwannomas, adenocarcinomas, ectopic thyroid tissue, or thyroglossal duct remnants.[3,4]

Many of the aforementioned lesions are similar in clinical appearance and can only be differentiated by means of histologic evaluation. Traditional imaging techniques (simple x-rays, computed tomography scans, magnetic resonance) are often altered by dental implants or fillings. Tongue lesions are therefore frequently removed on the basis of the findings of physical examination alone.[5]

The generalized use of dermatologic ultrasound in the last 10 years has included the inspection of mucosal tissues, but few cases extending this application have been reported in dermatology journals. All such descriptions available have been published in journals of oral medicine or maxillofacial surgery. The lesions described are usually oval, well-defined but not encapsulated, and heteroechoic (iso- or hypoechoic with respect to surrounding structures). They have absent or very weak Doppler signals (Table 1). There might be slight posterior acoustic enhancement. Short, parallel hyperechoic bands are less often seen in these lipomas than in those at other locations.[2,5]

A lesion on the tongue is examined in much the same way as lesions elsewhere. The anterior two-thirds of the tongue can usually be examined without assistance, but given the limited space in the mouth it may be useful to use a smaller or ''hockey-stick'' probe to facilitate mobility. A protective shield is necessary when examining mucosal tissue, and the patient should be informed that the gel used for dermatologic ultrasound is nontoxic.

Ultrasound imaging can help the dermatologist evaluate a lesion's size, shape, degree of vascularization, and attachment to other structures and should be considered for the differential diagnosis of tongue lesions.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

References

1. Egido-Moreno S, Lozano-Porras AB, Mishra S, Allegue-Allegue M, Marí-Roig A, López-López J, et al. Intraoral lipomas: Review of literature and report of two clinical cases. J Clin Exp Dent. 2016;8:e597–603.
2. Boffano P, Gallesio C. Lipoma of the tongue. N Engl J Med. 2012;367:e37.
3. Baonerkar HA, Vora M, Sorathia R, Shinde S. The lipoma of tongue. A rare site for a tumor: Case report and review of the literature. Indian J Dent. 2015;6:207–10.
4. Magadum D, Sanadi A, Agrawal JM, Agrawal MS. Classic tongue lipoma: A common tumour at a rare site. BMJ Case Rep. 2013, http://dx.doi.org/10.1136/bcr-2012-007987.
5. Sugawara C, Takahashi A, Kawano F, Kudo Y, Ishimaru N, Miyamoto Y, et al. Intraoral ultrasonography of tongue mass lesions. Dentomaxillofac Radiol. 2016;45:20150362.

J. Ruiz-Rivero,[a,*] B. Echeverría-García,[a] J.C. Tardío,[b] J. Borbujo[a]

[a] *Departamento de Dermatología y Venereología Médico-Quirúrgica, Hospital Universitario de Fuenlabrada, Madrid, Spain*
[b] *Departamento de Anatomía Patológica, Hospital Universitario de Fuenlabrada, Madrid, Spain*

* Corresponding author.
E-mail address: Juncal.ruiz@madrid.salud.org
(J. Ruiz-Rivero).
1578-2190/

Daylight Photodynamic Therapy in the Treatment of Actinic Keratosis in Carriers of Oculocutaneous Albinism: Report of Three Cases☆

Terapia fotodinámica con luz de día en el tratamiento de queratosis actínicas en pacientes portadores de albinismo oculocutáneo: presentación de 3 casos

To the editor:

Oculocutaneous albinism (OCA) leads to hypopigmentation of the skin, hair and eyes .[1] The most severe phenotype, OCA1, is characterized by the complete lack of melanin production; in subtypes, OCA2, OCA3, and OCA4, some pigment production occurs over the years.[2]

Actinic keratosis (AK) are premalignant lesions of the skin, commonly located in areas exposed to ultraviolet (UV) radiation.[3] OCA patients have an exaggerated sensitivity to UV radiation, which leads the onset of AK lesions and squamous-cell carcinomas, even at young age.

In daylight PDT (DL-PDT), the activation of the photosensitizer protoporphyrin IX (PpIX) from the methylaminolevulinate (MAL) cream by visible light, allows the treatment of AK with less adverse effects of pain and erythema ,[4] which favors its use as an alternative to conventional PDT in patients with excessive photosensitivity.[5] Other therapeutic options focused on the field of cancerization, such as imiquimod and 5-fluorouracil creams require long-term home treatment regimens and may lead to intense local skin reactions while, ingenol mebutate gel is usually limited to areas of up to 25 cm^2 . Thus, the treatment of AK with DL-PDT presents a number of advantages in patients with OCA, in comparison with other treatments.

In 2015, we treated the first patients with OCA at Dona Libânia Dermatology Center in Fortaleza, Brazil. There were

☆ Please cite this article as: Garcia Galvão LE, Tomaz R, de Sá Gonçalves H. Daylight Photodynamic Therapy in the Treatment of Actinic Keratosis in Carriers of Oculocutaneous Albinism: Report of Three Cases. Actas Dermosifiliogr. 2019;110:407–410.