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Molluscum Contagiosum on the Palms: An Uncommon Location☆

Molusco contagioso palmar, una localización excepcional

To the Editor:

Molluscum contagiosum (MC) is a very common infectious dermatosis. It is caused by a double-strand DNA virus of the same name, which belongs to the *Poxviridae* family. Estimated prevalence is 7% in children and up to 18% in immunocompromised adults. The virus is transmitted by direct contact, fomites, or autoinoculation, and manifests clinically in the form of cupuliform umbilicated papules that the same color as the skin and generally asymptomatic. The papules infrequently appear on glabrous skin.[1]

A 43-year-old man with no past medical history of interest visited our department with 2 lesions on the right hand; the lesions caused discomfort when pressed or rubbed and had appeared a week earlier. Physical examination revealed 2 erythematous papules on the hypothenar region of the left palm, with diameters of 2 and 4 mm, respectively. Both lesions were slightly infiltrated to the touch and the larger lesion showed central hyperkeratosis and a perilesional erythematous halo (Fig. 1). The rest of the physical examination was normal. One of the lesions was excised and biopsied, and showed lobulation of the epidermis toward the dermis, and keratinocytes with intracytoplasmic inclusion bodies (Fig. 2). The diagnosis of palmar MC was established based on these findings and the other lesion was treated using cryotherapy. Both lesions resolved completely a month after treatment.

In children, infection by the MC virus tends to be located on the face, torso, and extremities. In adults, the most frequent site is in the genital region and surrounding areas.[2] Involvement of the palms and soles is exceptional regardless of age. The first case of plantar MC was published by

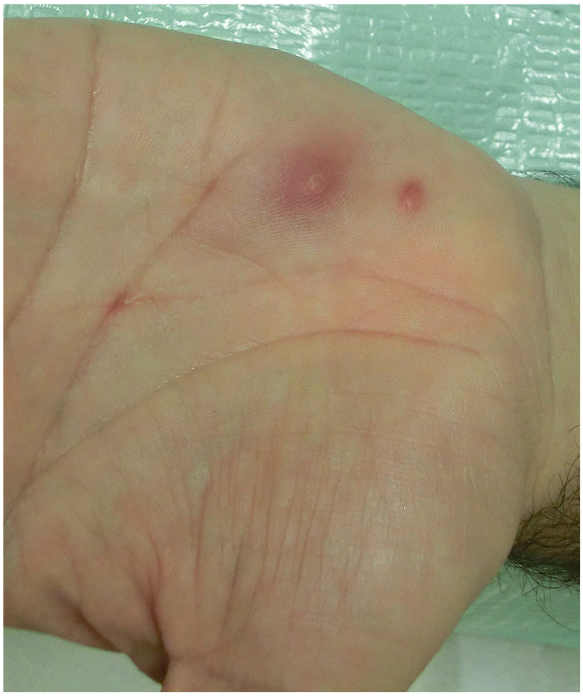

Figure 1 Two erythematous papules with diameters of 2 and 4 mm, respectively. The larger papule shows central hyperkeratosis and a perilesional erythematous halo.

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Table 1 Well-Documented Clinical Cases of Infection With Plantar or Palmar Molluscum Contagiosum to Date.

Reference	Sex and Age	Number of Lesions	Largest Diameter, cm	Site	Pain
Baxter y Carson[6] (1964)	Male, 21 years	50-60	0.1	LF	No
Perry GM (1964)	Female, 31 years	1	ND	RF	ND
Strani (1967)	Female, 75 years	1	ND	LF	Yes
Strani (1967)	Male, 7 years	1	ND	RF	Yes
Bunney et al. (1969)	Female, 21 years	> 5	ND	LF	ND
Zichichi (1969)	Male, 23 years	1	1.5	RF	Yes
Campanelli et al. (1978)	Female, 17 years	1	1.2	RF	Yes
Dickinson et al. (1983)	Male, 21 years	2	1/0.3	LF/RF	ND
Ha et al. (1998)	Male, 5 years	1	1.5	LF	Yes
Köse et al. (2009)	Female, 35 years	1	0.5	LF	Yes
Cohen and Tschen[5] (2012)	Male, 23 years	3	0.8/0.8/0.8	RF	Yes
Aydoğan et al.[7] (2014)	Male, 26 years	1	1	RF	No
Bahali et al.[8] (2016)	Male, 36 years	> 10	0.4-2	LF	Yes
García-Montero et al. (2017)	Male, 48 years	2	0.2/0.4	LH	Yes

Abbreviations: LH indicates left hand; ND, not described; RF, right foot, LF, left foot.

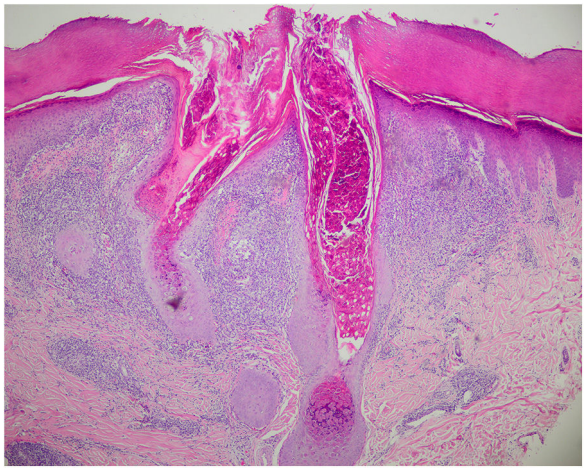

Figure 2 Lobulation of the epidermis toward the dermis and keratinocytes with intracytoplasmic inclusion bodies (hematoxylin–eosin ×4).

Ingram et al.[3] in 1957. To date, a total of 37 cases have been described but only 13 are well documented (Table 1). Involvement of the palms, however, was first described by Legrain and Pierard[4] in 1985 and no new cases have been published to date.

The diagnosis of palmar or plantar MC is rarely initially suspected because, as with our patient, the lesions do not tend to present the usual characteristics of infection by this virus. On the soles of the feet, clinical manifestations have been described as single or multiple papules or nodules with varying coloration (normal skin, erythematous, brown, translucent, yellow) and with hyperkeratotic, verrucous, or crusted.[5] Only Baxter et al. documented a case in which the lesions presented as umbilicated papules with a central keratin plug.[6] Clinical history cannot always guide diagnosis. Our patient had not suffered from this infection in the past, had no lesions in other areas at the time of the consultation, had not been in situations with a risk of infection, and only noted that one of his children had had MC a year earlier.

While infection with the MC virus is more frequent in childhood and in immunocompromised patients, most cases of palmoplantar involvement, including our case, have been reported in adults, and none patients in the published cases were immunocompromised. Past history of trauma or plantar hyperhidrosis have been identified in some patients and it is thought that they may have acted as predisposing factors.[7,8] Given that this is a highly prevalent infection, it is not known why it is not seen in this location more frequently, unlike papilloma virus. It may be that the thickness of the stratum corneum on the palms and soles makes entry of the poxvirus more difficult, as it is much larger (150-300 nm) than the human papilloma virus (60 nm). Palmoplantar involvement also shows that the virus replicates in the keratinocytes and does not require hair follicles.

The differential diagnosis with this type of lesion on the palms or soles is extensive and includes viral warts, pyogenic granuloma, foreign body granuloma, pleomorphic fibroma, carcinoma cuniculatum, and eccrine poroma. Treatment of palmoplantar MC is the same as at other sites.[9] In our patient, a single cycle of cryotherapy was effective and the lesions resolved completely in 1 month.

In conclusion, we report the second case of MC on the palm of the hand to date. This entity should be considered when we find papular lesions on the palms or soles, especially in patients with a personal or family history of risk, in order to perform a correct diagnosis.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Morphea «En Coup De Sabre» at the Site of Healed Herpes Zoster Ophthalmicus☆

Morfea *en coup de sabre* sobre el área cutánea de un herpes zóster oftálmico cicatrizado

To the Editor:

Morphea ''en coup de sabre'' (MCS) is a type of linear morphea that can involve the frontal and parietal region of the scalp, and the face. It mainly affects the skin and subcutaneous tissue, resulting in cicatricial alopecia.[1,2] Morphea sites have been reported to coincide with those of other, preexisting, inflammatory dermatoses, including herpes zoster. A thorough review of the English-language literature, however, found no report of MCS appearing at the site of healed herpes zoster ophthalmicus to date. We report what is probably the first case of MCS at the site of healed herpes zoster ophthalmicus.

A 40-year-old woman visited our department with changes in the color and texture of the skin on the forehead that had begun 2 months earlier. The lesions began insidiously and advanced to the frontal scalp, giving rise to cicatricial alopecia. The patient had no history of prior trauma, abnormal vision, headaches, or convulsions. Five months earlier, the patient had visited our department with painful lesions containing fluid around the left eye and on the forehead. The lesions were diagnosed as herpes zoster; the diagnosis was confirmed by means of the Tzanck test and the lesions were treated with 500 mg of famciclovir 3 times a day for 7 days. Remission of the lesions occurred over a period of 2-4 weeks, leaving residual hyperpigmentation and scarring. In the previous 2 months, the patient observed thickening and hardening of the scalp near the forehead but no involvement of the area around the left eye.

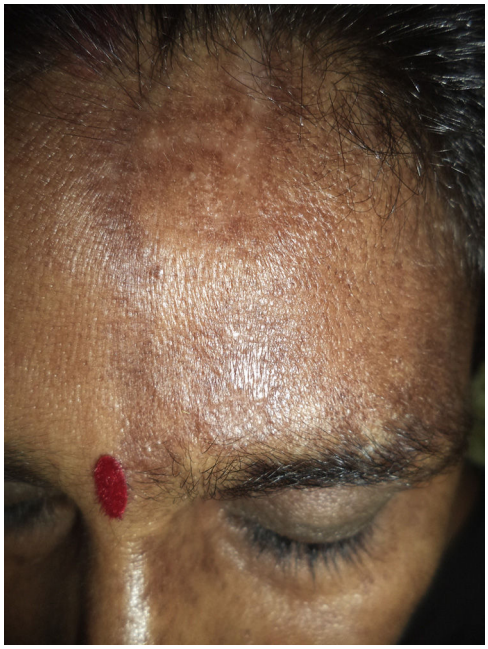

Figure 1 Band of thickened and indurated skin extending vertically along the forehead to the frontal scalp.

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