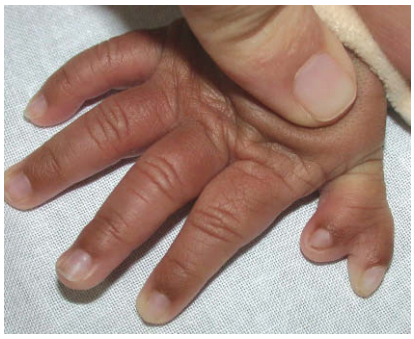

Figure 2. Polydactyly and syndactyly of the thumbs.

the diagnosis of membranous aplasia cutis congenita (ACC) of the scalp with hair collar sign, associated with polydactyly and syndactyly. This diagnosis could correspond to ACC group 1 of the scalp with no associated abnormalities or associated with isolated anomalies.[3]

Two aspects should be mentioned in relation to this case. First of all, a comprehensive assessment should be performed on any congenital lesion of the midline before surgical excision or biopsy. Computed tomography is the most accurate method for assessing cranial defects. Any bone defect observed with this method should be examined by magnetic resonance imaging to determine if there is transcranial extension of soft tissue. If there is no cranial defect and the lesion is consistent with membranous aplasia cutis, then biopsy is not necessary. Secondly, the association of various cutaneous markers on the scalp, such as the hair collar sign and vascular malformations, increases the possibility of associated cervical dysraphism.[4,5]

References

1. Commens C, Rogers M, Kan A. Heterotropic brain tissue presenting as bald cysts with a collar of hypertrophic hair. Arch Dermatol. 1989;125:1253-6.
2. Drolet B, Prendiville J, Golden J, Enjolras O, Esterly NB. Membranous aplasia cutis with hair collars. Congenital absence of skin or neuroectodermal defect? Arch Dermatol. 1995;131:1427-31.
3. Frieden IJ. Aplasia cutis congenita: a clinical review and proposal for classification. J Am Acad Dermatol. 1986;14: 646-60.
4. Herron MD, Coffin CM, Vanderhooft SL. Vascular stains and hair collar sign associated with congenital anomalies of the scalp. Pediatr Dermatol. 2005;22: 200-5.
5. Fujita Y, Yokota K, Akiyama M, Machino S, Inokuma D, Arita K, et al. Two cases of atypical membranous aplasia cutis with hair collar sign: one with dermal melanocytosis, and the other with naevus flammeus. Clin Exp Dermatol. 2005;30:497-9.

Obtention of a Panoramic Histological View with Dermatoscopy

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To the Editor:

In dermatological pathology, a panoramic view of the histological specimen being examined is important. A panoramic histological view allows assessment of the localization of the skin condition, as well as identification of certain inflammatory or tumor patterns and/or architecture that may aid the diagnosis.

A panoramic view of a histological specimen will require a photographic camera fitted to a microscope that, in addition to the usual lenses (4×, 10×, 20×, 40×, and 100×), has a 1.25× or 2× zoom lens or magnifying lens. A lens of this type is often expensive and not always available. As a result, adequate images are often missing from most dermatopathological publications and reports.

A course on diagnosis in dermatological pathology was recently taught by Dr Requena and Dr Sánchez-Yus in Madrid, Spain, in which emphasis was placed on the importance of panoramic views of dermatological lesions for diagnosis. Some of the panoramic histopathological images shown in the course had been taken with a single-lens reflex camera directly focused on the slide. Our department is equipped with a DermLite FOTO37 dermatoscope coupled to a Nikon Coolpix 4500 camera, leading us to consider using that equipment with a histological specimen to obtain a good panoramic magnified view.

A dermatoscope is an optical system involving polarized light. The magnification ranges from 10× to 400×, or even more. The dermatoscope was designed to assist in the specific diagnosis of pigmented skin lesions, but has also been used in the diagnosis of other lesions, such as vascular, inflammatory, or parasitic lesions.[1] In rheumatology, the dermatoscope is used by some specialists as a capillaroscope.[2]

The DermLite FOTO37 is a 10× dermatoscope that can acquire digital images when coupled to a digital camera.

We present a collection of histological images obtained with this digital photographic system using the steps listed below (Figures 1 and 2). First, we ensured that the dermatoscope, camera lens, and glass slide with the histological specimen to be photographed were clean. We then placed the glass slide with the histological specimen over a white, nonreflective surface, for instance,

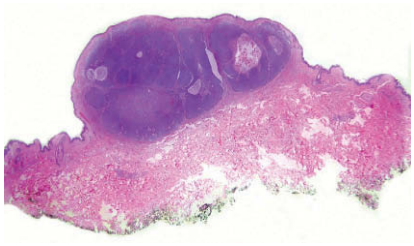

Figure 1. Basal cell carcinoma (Hematoxylin-eosin).

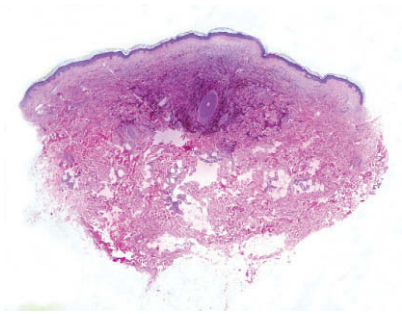

Figure 2. Blue nevus (Hematoxylin-eosin).

Figure 3. Position of camera, dermatoscope, and microscope slide to obtain the panoramic image.

white card. We selected the macro function in the digital camera, switched off the flash, and turned on the polarized light of the dermatoscope. We placed the dermatoscope over the preparation, as when taking a dermatoscopical image of skin, and focused on the histological specimen (Figure 3). Lastly, we took the picture.

References

1. Arrazola P, Mullani NA, Abramovits W. Derlite II: an innovate portable instrument for dermoscopy without the need of immersion fluids. Skinmed. 2005;4:78-83.
2. Bergman R, Sharony L, Schapira D, Nahir MA, Balbir-Gurman A. The handheld dermatoscope as a nail-fold capillaroscopic instrument. Arch Dermatol. 2003;139:1027-30.

Sporotrichoid Cutaneous Leishmaniasis

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To the Editor:

The leishmaniases are parasitic diseases caused by intracellular protozoa of the *Leishmania* genus. These microorganisms are transmitted by the bite of the female of the fly belonging to the *Phlebotomus* genus in the Old World and *Lutzomya* in the New World. The clinical manifestations of the leishmaniases are extremely varied, and cutaneous, mucocutaneous, and visceral forms of the disease have been described.[1,2] We present a case of cutaneous leishmaniasis with sporotrichoid spread, a rare variant of this entity that is unusual in Spain.

A 63-year-old woman of Ecuadorian origin and no history of interest consulted 3 weeks after her arrival in Spain for a lesion in the facial region that had been present for 2 months. The lesion showed progressive growth and was occasionally pruritic. The patient reported no other associated symptoms and had no recollection of insect bites or trauma prior to appearance of the lesion.

The physical examination showed an infiltrated plaque of about 3×3 cm in diameter, located on the left mandibular ramus. The surface was smooth, shiny, and erythematous, and presented a small ulceration covered by a crust. In addition, indurated lymph nodes and small subcutaneous nodules were palpable around the periphery of the lesion, along the path of the proximal lymph node chains (Figure 1).

Complete blood count, blood biochemistry, protein analysis, chest x-ray, and bone marrow aspirate were normal. Exudate cultures were negative for bacteria, fungi, and mycobacteria.

Giemsa stain of the exudate smear showed amastigotes inside and outside the histiocytes.

Histology revealed a dense inflammatory infiltrate composed of lymphocytes, plasma cells, and some eosinophils, along with macrophages infested with oval basophilic microorganisms with an eccentric kinetoplast and with no capsule (Figure 2).