

81% of cases of nevoid melanoma presented nests arranged in a parallel theque pattern in the basal layer of the tumor, which could aid diagnosis. Genetic techniques including fluorescent in situ hybridization and comparative genomic hybridization (CGH) have been shown to be useful in the differentiation between melanoma and melanocytic nevus. In that study, CGH detected genetic changes in 7 of the 8 cases in which the test was performed.

Nevoid melanomas appear to carry a poorer prognosis than other types described in the different series, with metastasis rates of 15% to 37.5% and a mortality of between 25% and 37.5% (series by Schmoeckel et al.¹ and series by Idriss et al.⁷). In our patient, SLNB was performed despite the site being on the head and neck, which can make the technique more difficult, and, in accordance with the melanoma committee, local radiotherapy was administered.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Double Hatchet Flap For The Reconstruction Of Scalp Defects[☆]



Reconstrucción de defecto en cuero cabelludo mediante doble colgajo en hacha

To the Editor:

The scalp is a relatively common site for skin tumors. The lack of cutaneous elasticity and the high frequency of actinic damage can limit the choice of reconstruction techniques, particularly in medium-sized or large defects. One of the most widely used flaps is the double hatchet flap, which is a good option with excellent cosmetic results.

We present the case of a 62-year-old patient with a past history of hypertension and diabetes mellitus. He was referred to our outpatient clinic for a basal cell carcinoma measuring 3.4 × 3.5 cm in the right parietal region (Fig. 1A). After histological confirmation by biopsy, surgical excision under local anesthesia and sedation was scheduled.

The resulting surgical defect measured approximately 4.2 × 5.7 cm; the periosteum was intact. A bilateral hatchet flap was designed (Fig. 1B); the length of each flap was 1.5 times the diameter of the defect and the pedicle was a third of the length of the flap. Dissection was performed in the subgaleal plane (Fig. 1C), and the defect was closed by tissue planes, with placement of a drain posteriorly (Fig. 2A). The drain was removed the following day. The cosmetic result was excellent, with a minimal residual scar (Fig. 2B), and there were no signs of recurrence after a year of follow-up.

Tumors are not uncommon on the scalp, and can sometimes be large lesions that require laborious surgical techniques.

The options for reconstruction include closure by second-intention, which is possible when the periosteum is preserved.^{1,2} This is an acceptable option in small defects and in patients of advanced age or with comorbidities, although healing time is prolonged and the scar is depressed and alopecic. Another possibility is a graft, which usually achieves a poorer cosmetic result than a plasty, and leaves an area of alopecia.

Several flaps may be considered. Advancement, rotation, and transposition flaps are usually good options in defects that require special anatomical modifications. Specifically, advancement and transposition plasties are used less frequently, although they may be considered to be an option for reconstruction, depending on the size and site of the defect. The anatomical convexity makes rotation flaps and combined rotation-advancement flaps the most useful

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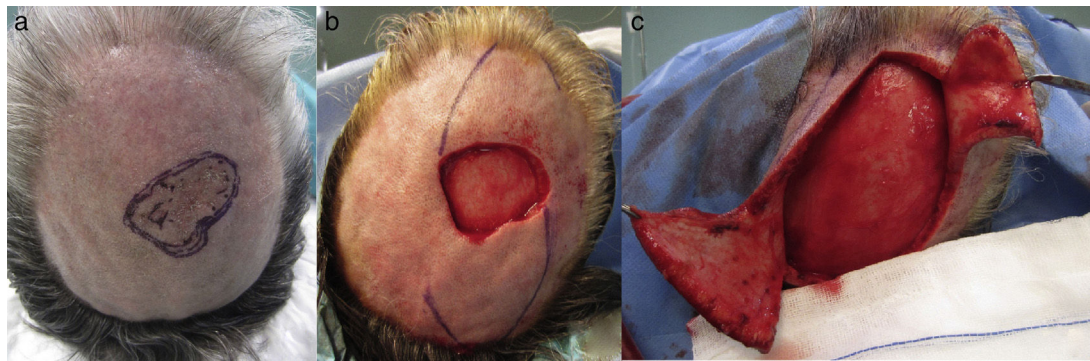


Figure 1 A, Lesion to be excised (basal cell carcinoma). B, Design of the double hatchet flap. C, Dissection of the flap in the subgaleal plane.



Figure 2 A, Immediate postoperative result. B, Final outcome 2 months after the operation.

alternatives. These include the double hatchet flap and the O-Z flap, which is widely used for the reconstruction of scalp defects.

Free vascularized flaps are technically more complex and require hospital admission. Also, they are more expensive in the short and medium term.

It must be noted that when the defect includes the periosteum, leaving the cortical or even spongy bone exposed, the only reconstructive options are local plasty and free vascularized flaps, as a graft in this situation would have no vascular bed from which to draw nutrients and establish its blood supply, and would thus be lost.

The double hatchet flap, first described by Emmet in 1977, is a particularly useful option for the reconstruction of small and medium-sized scalp defects.^{1,3} It is a triangular plasty with a random vascular pattern that allows a dou-

ble movement of rotation and advancement, facilitated by a tension-releasing design at its base, enabling closure of larger-diameter defects.³ This procedure can be performed in a single operation, on an ambulatory basis under local anesthesia, except for large defects that may require sedation and a short hospital admission.³

When designing the flap, the reference measurement after the circular excision of a lesion is the diameter of the defect; the length of the flap must be 1.5 times the diameter of the defect and the vascular pedicle must be at least a third of the length of the flap. Dissection is performed in the subgaleal plane, which will provoke less hemorrhage and preserve the supragaleal vascular bed. The disadvantage of this plane of dissection is the limited elasticity of the tissue, requiring broader release to achieve greater mobility of the plasty and thus distribute the tension across the surgical wound, avoiding complications such as

dehiscence. Closure is performed by tissue planes, with a V-Y suture.

Close follow-up is required in the immediate postoperative period, with regular wound care.

The cosmetic result of the double hatchet flap can be excellent, as tissue of similar characteristics is used, with preservation of hair, texture, and thickness,³ rapid healing, and minimal scarring and comorbidity. Possible complications include flap necrosis, dehiscence, and the formation of hypertrophic scars.^{1,2,4,5}

For all these reasons, the double hatchet flap is one of the best techniques for its simplicity of design, speed of performance, ease of postoperative care, and excellent result in the medium and long term.⁵

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Linear IgA Bullous Dermatitis Presenting as Toxic Epidermal Necrolysis[☆]



Dermatitis ampollosa IgA lineal con presentación clínica de necrólisis epidérmica tóxica

To the Editor:

Linear immunoglobulin (Ig) A dermatitis (LAD) is a rare autoimmune bullous disease characterized by the formation of subepidermal blisters with linear deposits of IgA along the basement membrane, visible on direct immunofluorescence.^{1–3} Cases of LAD mimicking other blistering diseases, such as bullous pemphigoid, pemphigus vulgaris, dermatitis herpetiformis, and impetigo, and nonbullous diseases have been reported.^{4,5}

We present the case of an 88-year-old woman receiving palliative care for metastatic squamous cell carcinoma of the vulva. She was admitted to internal medicine for cellulitis of the right lower limb, for which the portal of entry was an ulcer in the right inguinal region. Computed tomography revealed a right inguinal fluid collection of 11 cm in diameter, with gas, and osteomyelitis of the pubis that required urgent surgical debridement. The patient devel-

oped sepsis and treatment was started with ertapenem and vancomycin. Five days later, the dermatology department was consulted for the appearance of widespread desquamating erythematous lesions on the face, trunk, and limbs (Fig. 1A). Despite withdrawal of the vancomycin for suspected toxic epidermal necrolysis (TEN), LAD, or other drug-related hypersensitivity syndromes, the condition progressed to erythroderma in the space of 24 hours, with tense blisters, erosions, and epidermal separation in pressure areas (Figs. 1B and 2A), with involvement of the oral mucosa, but not of other mucosae. In view of the patient's basal situation, she was not a candidate for transfer to a specialist burns unit. Treatment was started with systemic corticosteroids and, given the lack of response, it was decided to administer immunoglobulins at a dose of 0.4 g/kg/d for 5 days. However, the condition progressed to widespread epidermal detachment (Fig. 2B) and the patient died 7 days later. Skin biopsy (Fig. 3A) revealed an epidermis with a normal maturation gradient and subepidermal vesicles full of a fibrinoid material with polymorphonuclear cells and eosinophils; these findings were consistent with a diagnosis of LAD. The superficial dermis showed a mild perivascular lymphocytic and eosinophilic inflammatory infiltrate. On direct immunofluorescence (Fig. 3B), a linear deposit of IgA was visible along the dermoepidermal junction, with no other pathological deposits with the antisera tested (fibrinogen, IgG, IgM, and complement component C3). Indirect immunofluorescence on 1 M sodium chloride-separated skin, showed the deposits to be on the epidermal side of the vesicles.

The first descriptions of LAD are attributed to Bowen in 1901, although it was not until 1979 when it was considered a separate entity from dermatitis herpetiformis.⁵ LAD is a clinically and histologically heterogeneous condition that

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