higher magnification shows that the spindle cells express normal interspersed collagen bundles (C3b, H&E, ×200).

This treatment results in tumor regression in patients. Therefore, this treatment may be effective when the disease advances in patients. The appearance of multiple DF treated with brentuximab vedotin showed a greater than 30% reduction in tumor size on the arm and the leg over a short period of time.

In our case, the immunomarkers panel of CD30, CD15, and CD68 helped us to confirm the diagnosis of DF with CD30+ T cells. Since its description in 1970, its histological diagnosis has been reported as high-frequency disease associated with a few cases of DF treated with brentuximab vedotin. Therefore, the use of免疫 markers and CD30+ T cells could help us to diagnose DF accurately in the early stage of the disease.

In this case, the patient presented with multiple DFs on the left arm and legs, which were treated with brentuximab vedotin. The DFs showed a significant decrease in size after treatment, indicating the potential efficacy of brentuximab vedotin in treating DFs.

We present the case of a 51-year-old woman diagnosed with DF, who showed a significant decrease in tumor size after treatment with brentuximab vedotin. The immunohistochemical study revealed the presence of CD30+ T cells in the tumor, confirming the diagnosis of DF. The patient was treated with brentuximab vedotin, and a significant decrease in tumor size was observed on follow-up imaging. This case highlights the potential effectiveness of brentuximab vedotin in treating DFs, and further studies are needed to confirm its efficacy and safety in this patient population.
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


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

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 cicatricial 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.

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