Pseudoepitheliomatous Hyperplasia Arising from Hypertrophic Lichen Planus Mimicking Squamous Cell Carcinoma: Limited Value of Immunohistochemistry

INTRODUCTION
Hypertrophic lichen planus shows prominent hyperplasia and overlying orthokeratosis of the epidermis. To date, 50 cases of squamous cell carcinoma (SCC) have been reported as neoplastic transformation of hypertrophic lichen planus. We report a case of pseudoepitheliomatous hyperplasia (PEH) simultaneously found in hypertrophic lichen planus lesions simulating SCC, with special reference to the value of immunohistochemistry in differential diagnosis.

CASE REPORT
A 73-year-old woman presented with multiple erosive lesions of the oral cavity. Biopsy showed a subepithelial chronic inflammatory infiltrate that did not permit to establish the etiopathogenetic nature. Clinical examination showed multiple hyperkeratotic nodules of 14-month duration located especially on both heels and toes (Fig. 1). Biopsies of the two lesions showed typical features of hypertrophic lichen planus in continuity with an adjacent area of PEH (Fig. 2). Shave biopsy of the smallest hyperkeratotic nodule was diagnosed as well-differentiated SCC (Fig. 2). Histology of the latter nodule revealed benign irregular hyperplasia of the epidermis with gross acanthosis, downward proliferation with moderate dyskeratosis and horn cyst formation (Fig. 2). These features are typical of PEH. Shave biopsy of the smallest hyperkeratotic nodule was diagnosed as well-differentiated SCC. Excisional biopsy of another nodule showed benign irregular hyperplasia of the epidermis with gross acanthosis, downward proliferation with moderate dyskeratosis and horn cyst formation. These features were typical of PEH. In both specimens, squamous proliferation showed diffuse nuclear p53 expression. Nuclear staining was stronger in the basal cells. E-cadherin showed uniform membranous staining in epithelial growths of both specimens. Ki-67 expression was observed prevalently in the basal layer (Fig. 3). In both specimens, there were a decreased number of CD1a-positive cells, compared to the normal adjacent epidermis. Review of the first biopsy, considering further clinical findings, suggested a diagnosis of PEH rather than squamous cell carcinoma. After two years, the patient is free from recurrence.

DISCUSSION
PEH is a histopathologic reaction pattern rather than a disease sui generis. It is characterized by irregular hyperplasia of the epidermis, which also involves follicular infundibula and acrosyringia. This proliferation may be encountered in a number of clinically heterogeneous diseases. PEH may be misinterpreted as SCC especially in cases in which the primary process localized in the dermis is not readily apparent or the biopsy is superficial and does not include sufficient portion of the dermis. If epidermal hyperplasia is severe, it may mimic SCC on shave biopsy (1). Numerous reported SCCs arising in hypertrophic lichen planus may not be accepted as such because the hypertrophic lichen planus-squamous cell carcinoma sequence is not sufficiently histologically illustrated (2-5). Since PEH may simulate SCC, accurate criteria should be used on differential diagnosis. In our case, the infiltrative pattern was alarming and a precise diagnosis problematic. Immunohistochemistry has been used on diagnostic differentiation between PEH and SCC. Lee et al. (6) examined p53 expression in 6 PEH and 45 SCC cases. p53 expression was observed...
of Langerhans cells compared to the normal epidermis (9,10). As SCC also has a decreased numbers of CD1a positive cells, this stain is not useful in differentiating these two entities.

**CONCLUSIONS**

We believe that the presence of multiple lesions, follow-up and proliferation from follicular infundibula are valuable criteria indicating PEH rather than SCC. Distinguishing PEH and SCC may be challenging for pathologists, especially in small and limited biopsies because excisional biopsies are the best diagnostic procedure. Immunohistochemistry is not useful in differentiating these two entities.

**References**

Trachyonychia in an Adult with Excellent Recovery

INTRODUCTION

Trachyonychia is a rare benign nail disorder that is most commonly found in childhood. It may involve one, several or all digits. When most or all digits are involved, the term twenty-nail dystrophy is commonly used. We report a 41-year-old male presented with all fingernails and most toenails affected due to spongiotic inflammation of the nail matrix, which markedly improved after 4-month treatment with topical corticosteroid.

CASE REPORT

A 41-year-old male patient presented with a 4-year history of dystrophy involving most of the twenty fingernails and toenails. He denied any family history of atopic disease, alopecia areata, etc. Several courses of a systemic antifungal agent were ineffective. Physical examination revealed most of the nails to be opaque, lusterless and rough; the nail plate surface showed longitudinal ridging due to fine superficial striations distributed in a regular, parallel pattern. A few toenails showed a myriad of small punctuate depressions distributed in a geometric fashion along longitudinal and parallel lines (Fig. 1a). The skin of the scalp, trunk and extremities was not involved. Histopathologic examination of the longitudinal and lateral part of the right big toenail showed thickened stratum corneum with numerous parakeratotic cells and general acanthosis of the epidermal layer, evolution from spongiosis to spongiotic vesiculation and...
a dense inflammatory infiltrate of lymphocytes with varying numbers of eosinophils in the epidermis and upper dermis (Fig. 2). The patient made an excellent recovery with topical corticosteroid treatment (halometasone 1% ointment) for 4 months (Fig. 1b).

DISCUSSION

The term trachyonychia was first coined by Alkiewicz (1) in 1950 to describe idiopathic nail roughness (1). Identical nail changes were reported under the diagnosis of 20-nail dystrophy by Hazelrigg et al. in 1977 (2), who described six children with idiopathic nail roughness involving all nails. Based on the appearance, trachyonychia is traditionally divided into two groups: opaque trachyonychia and shiny trachyonychia (3). Sometimes the two varieties may coexist in the same patient.

Trachyonychia is more common in children but actually it may affect patients from all age groups, as in this case. It is a descriptive clinical pattern of nail changes and controversy remains with respect to its cause (4). Several inflammatory diseases of the nail matrix may produce trachyonychia. It is most commonly due to spongiotic changes of the proximal nail matrix, which may also be found in psoriasis and lichen planus (5-7). All these diseases result in abnormal keratinization of nail matrix onychocytes that retain their nuclei and, instead of maturing to form a compact layer of tightly adherent flat cells, produce a stratum corneum-like layer that easily desquamates. But interestingly, severe alopecia areata is also frequently associated with trachyonychia (4). So, complete examination of the skin, hair and mucosae is necessary to detect an associated disease when the diagnosis of trachyonychia is made.

Nail biopsy is an invasive procedure, which is not recommended to be performed routinely in patients with trachyonychia. Because the systemic antifungal agent failed in this patient, we had to perform nail

![Fig. 1.](image1) (a) Most fingernails and toenails opaque, lusterless and rough; (b) nail appearance after 4-month topical treatment.

![Fig. 2.](image2) (a) An inflammatory infiltrate with spongiosis and acanthosis of the nail plate (left) and matrix (right) (hematoxylin-eosin, original magnification ×40); (b) eosinophilic spongiosis in the epidermis (HE ×400).
biopsy and discovered the cause of this case was spongiotic inflammation of the nail matrix with a lot of eosinophils observed in the epidermis and upper dermis. Thus, eczema was the cause of this case of trachyonychia. Trachyonychia is a benign condition and Sakata et al. (8) report on 50% of their patients to have achieved either total resolution or marked improvement in their nail disease within the first 6 years regardless of treatment. With regard to cosmetic appearance, the patient received topical corticosteroid treatment and showed excellent recovery within only 4 months. Yet, more cases are required to give a more comprehensive evaluation of the disease.

References

Han Ma, Chun Lu, Pei-ying Feng, Mei-rong Li
Department of Dermatology, Third Affiliated Hospital, Sun Yat-sen University, Guangzhou, Guangdong, China
Corresponding author:
Prof. Chun Lu, MD, PhD
Department of Dermatology
Third Affiliated Hospital
Sun Yat-sen University Guangzhou
Guangdong 510630
China
luliyuan@tom.com

Received: July 14, 2011
Accepted: May 15, 2012
Entomodermoscopy in Scabies – Is It a Safe and Friendly Screening Test for Scabies in Children?

INTRODUCTION

Scabies belongs to a group of infectious diseases commonly present in children, caused by Sarcoptes scabiei var. hominis infestation. Clinical presentation is characteristic, with typical itching papules, excoriations and accompanying strong itching, especially after the body has been warmed up (after a warm bath or at night). However, in some cases, this may be clinically ambiguous. In diagnostically difficult cases, in children with a small amount of changes and with an uncharacteristic course, an auxiliary dermoscopic examination can be performed. Dermoscopy belongs to a group of safe, noninvasive methods of skin examination in vivo, and recently, it has been ever more frequently used in the diagnosis of infectious diseases, such as scabies, pediculosis, mycosis and viral warts (1,2). So far, dermoscopy has been employed for differential diagnosis of pigmented skin changes (mostly of melanoma, melanocytic nevi), as well as skin cancers and inflammatory dermatoses such as psoriasis or lichen planus (3). Due to the more frequent use of dermoscopy in the diagnosis of parasitic skin diseases, the term entomodermoscopy has been created (1,4).

CASE REPORT

A 7-year-old preschool boy presented to a dermatologist because of quite intensive skin changes on the right hand, accompanied by itching all day long. The skin changes had first appeared about 14 days before dermatologic examination and were initially treated as contact dermatitis by a pediatrician, using ointment containing glycoestrogens. Other family members showed no such changes. Clinical examination showed 3 intensively red papules located on the lateral surface of the 3rd finger of the right hand. No other changes were found on the skin of the whole body, mucosa and scalp. Dermoscopic examination of the papule using a handle-dermoscope and videodermoscope with immersion oil showed the presence of scabies with a characteristic pattern, localized in a superficial burrow with black fecal pellets. The presence of a typical structure in the form of the tell-tale hang-glider-like triangle of the mite's head and round body was found. The mite was present in the burrow, at the end of which black masses of fecal pellets were found (Fig. 1). After local application of permethrin on the whole body once at night, improvement of the patient’s clinical condition was observed. The changes disappeared completely with no recurrences.

DISCUSSION

In pediatric practice, it is essential to reach a prompt diagnosis, which allows for implementation of the appropriate, effective treatment. The diagnosis should be undertaken using a noninvasive, painless, easily-repetitive method, which will not cause additional stress and pain related with the process of diagnosis itself or the treatment. In order to perform a proper diagnosis of scabies, the following should be taken into consideration: the patient's clinical history with epidemiological symptoms and detection of the mite (Sarcoptes scabiei). Diagnosis is confirmed if the mites or eggs are identified by microscopy or dermoscopy (5). Scabies is traditionally diagnosed clinically and confirmed by microscopic examination of typical z-shaped burrow skin scrapings, suspended in mineral oil or in saline. Visualization of the mites, eggs or feces confirms the diagnosis (6). Unfortunately, in some cases, not all physicians can perform microscopy, therefore dermoscopy consists of an alternative method of diagnosing scabies (1). Entomodermoscopy is currently used in the diagnosis of viral warts, molluscum contagiosum, scabies, pediculosis, tinea nigra, tungiasis, cutaneous larva migrans, ticks and reactions to spider leg spines (1,2). This examination can be performed by a handle-dermoscope (with a magnification of up to 10 times) and by videodermoscopy, allowing the physician to obtain skin magnification of even up to 70-100 times (3). It is recommended to use higher magnifications (from x60 to x200) on videodermoscopy of excoriations and burrows, which allows for better visualization of scabies structures. Very often, it is possible to find a typical dermoscopic aspect of the scabies mite at a distance. Dermoscopy allows for the identification of a triangular structure, which
corresponds to the anterior section of the mite including the mouth part and 2 pairs of frontal legs (7,8). This aspect has been described as resembling a jetliner with its trail, a delta glider or a spermatozoid (7). The female mite, approximately 0.4 mm in size, is visible as a mite possessing dark-brown capitulum and two pairs of forelimbs at the tip of the curved burrow (the irregularly reflected white area) and an almost transparent round body in its rear section (5). Dupuy et al. (9) compared the usefulness of microscopic examination of the skin scrapings ex vivo and of dermoscopic examination of the larvae in vivo. A group of 238 patients with suspected scabies infestation were subjected to the above mentioned examination, obtaining high sensitivity and specificity of both methods in the detection of Sarcoptes scabiei. The sensitivity of dermoscopic examination was 91% (95% confidence interval: 86-96), similarly to microscopic examination of skin scrapings (90%; 95% confidence interval: 85-96), with a slightly lower specificity of dermoscopic examination (86%; 95% confidence interval: 80-92), in comparison to 100% specificity of microscopic examination of skin scrapings resulting from the definition of this examination (9). The lower specificity of dermoscopic examination in scabies diagnosis may be due to insufficient experience of dermoscopists in particular cases (9). However, this method can be useful in cases where traditional diagnostic methods of observing scabies infestation do not work (for example, when the larvae are at a certain distance from their burrows) (7). This also applies to clinical observation after anti-scabies treatment in patients with chronic scabies and among their family members. We should remember that after treatment has taken place, dermoscopy does not distinguish whether the mite is alive or dead. Unless they are physically extracted, the effectiveness of the treatment process cannot be guaranteed. Videodermoscopy also enhances diagnostic capability in clinically uncharacteristic cases of scabies, or those which are not located in their most common, characteristic zones (10).

Entomodermoscopy is the perfect diagnostic tool for the diagnosis of scabies infestation accompanied by typical clinical symptoms. It is useful when there is no possibility to perform a standard microscopic examination, allowing for fast introduction of proper treatment. Scabies diagnosis in children and also among the elderly, with the use of dermoscopy, is more advantageous in comparison to microscopic examination, since it causes no fear, pain or bleeding. Certainly, using dermoscopy to examine children with an itchy rash is of relevance to clinical practice. The alternative is to extract the mite with a pincer, which requires much more skill and as a rule is not appreciated by kids. It does, however, allow for obtaining results in a short time without the need to collect skin scrapings.

Figure 1. Photographic image of scabies mite taken through a videodermoscope (original magnification x60). The mite is present in the superficial burrow (*), at the end of which one may find the presence of larvae feces in the form of dark, shapeless masses (marked area). The mite’s head (horizontal arrow) resembles the hang-glider-like triangle and round body (vertical arrows) corresponds to the scabies abdomen.
**CONCLUSION**

Dermoscopy and videodermoscopy allow for the diagnosis of scabies in children and the elderly. It is a better, cheaper and more convenient option than traditional methods of microscopic examination of skin scrapings.

**References**


**Grażyna Kaminska-Winciorek**
Department of Dermatology, Medical University of Silesia, Katowice, Poland

**Corresponding author:**
Grażyna Kamińska-Winciorek, MD, PhD
Department of Dermatology
Medical University of Silesia
ul. Francuska 20/24
Katowice 40-024
Poland
dermatolog.pl@gmail.com

Received: July 20, 2011
Accepted: March 8, 2012

---

**Leukocytoclastic Vasculitis Induced by Mycoplasma pneumoniae Infection**

**INTRODUCTION**

Leukocytoclastic vasculitis (LCV) is a histopathologic term used to describe a type of cutaneous small-vessel vasculitis. It may be triggered by various agents, but the definite cause can be found in only about half of cases. *Mycoplasma (M.) pneumoniae* may be involved, especially within a context of fever and skin eruption, even in the absence of respiratory symptoms. The classic clinical presentation of LCV is palpable purpura with symmetric distribution of lesions, most frequently involving the legs. The exact mechanism by which *M. pneumoniae* produces skin disease is poorly understood. In the case of LCV, it is assumed that the process is a type III reaction according to Coombs and Gell classification, in which the antigen combines with its specific antibody and complement to form circulating immune complexes that are deposited in the walls of the capillaries and venules. Here we present a case of a young patient that developed cutaneous vasculitis in the setting of *M. pneumoniae* pneumonia.
CASE REPORT

A 27-year-old man with a few days’ history of a nonpruritic purpuric rash on his chin and lower extremities accompanied by swelling and arthralgia was admitted to the hospital. He had had a fever 2 weeks before that required paracetamol for fever control and he had also taken azithromycin for 3 days. His medical history included epilepsy controlled by valproic acid and carbamazepine. On physical examination, purpuric maculae, papules, hemorrhagic blisters, and ulcerations on the lower extremities and the chin were found (Figs. 1 and 2). Physical examination revealed no further anomalies. Laboratory studies revealed an elevated C-reactive protein level (82 mg/L) and elevated erythrocyte sedimentation rate (74 mm/h) with a normal leukocyte count, whereas findings of routine blood chemistry profile and urinalysis were normal. Serologic tests were negative for antinuclear antibodies, antineutrophil cytoplasmic autoantibodies, anti-streptolysin O, cryoglobulins, rheumatoid factor, human immunodeficiency virus, and antibodies to hepatitis A, B, and C viruses. Circulating immune complex levels were elevated. *M. pneumoniae* IgM antibodies were positive according to enzyme immunoassay. *M. pneumoniae* infection was confirmed by polymerase chain reaction (PCR) of the pharyngeal swab. Chest radiograph showed an infiltrate of the right upper lobe (Fig. 3). Histopathologic examination of a skin lesion specimen from the chin showed endothelial cell swelling, fibrinoid changes of vessel walls in the dermis, and a neutrophilic perivascular infiltrate with leukocytoclasis and extravasated erythrocytes (Fig. 4). The patient was treated with oral moxifloxacin, which led to almost total resolution of the infiltrate as seen on chest radiograph. Prednisone therapy led to rapid regression of the skin lesions and the patient was discharged from the hospital in good condition.

DISCUSSION

*M. pneumoniae* is usually associated with respiratory tract infections. It is an important cause of a variety of respiratory tract infections and community-acquired pneumonia in children and young adults. Extrapulmonary complications occur in 10% to 25% of cases and can develop any time after the onset of respiratory symptoms or even in their absence (1).

The exact mechanism of the occurrence of extrapulmonary manifestations is poorly understood. Various pathogenetic mechanisms for extrapulmonary
manifestations have been proposed, which can be classified into the direct type, which results from a primary skin infection, and the indirect type, in which immune-mediated mechanisms play a role (1-6). Abnormalities in various organ systems have been described. Extrapulmonary manifestations include cutaneous, gastrointestinal, renal, hematologic, neurologic, cardiac, osteoarticular, ocular, and nonspecific complications, such as ear symptoms and acute rhabdomyolysis (5).

Cutaneous manifestations are common, occurring in 10% to 25% of cases, most commonly as exanthematous eruptions, erythematous maculopapular rash, or vesicular rash (6). Other dermatologic disorders associated with *M. pneumoniae* infection are erythema nodosum (4,7-9), urticaria (7,10), Stevens-Johnson syndrome (11-15), mucositis (15), pityriasis rosea (16), bullous erythema multiforme (17,18), toxic epidermal necrolysis (19), Kawasaki disease (20), subcorneal pustular dermatosis (21), thrombotic thrombocytopenic purpura (22), Henoch-Schönlein purpura (23), urticarial vasculitis (24), Raynaud’s phenomenon (25), and LCV (26-28). The pathogenesis of LCV is not fully understood. It is suggested that the interplay between autoimmune mechanisms and *M. pneumoniae* antigens could induce vasculitis, but the exact mechanisms remain unexplained.

In 2007, Greco *et al.* reviewed the literature on five cases of cutaneous vasculitis following infection with *M. pneumoniae*, including their case (28). This insignificant number of publications is probably due to empirical treatment without serologic confirmation, which leads to the under-diagnosis of this pathology.

Our patient developed clinically and histologically confirmed cutaneous vasculitis, presumably correlated with *M. pneumoniae* infection. It is also possible that LCV in our patient was triggered by drug ingestion, which is the most common cause of LCV. We assume that the LCV was the result of *M. pneumoniae* infection because of the clinical course and prompt response of the pulmonary infiltrate to antibiotic treatment. We demonstrated the *M. pneumoniae* infection by radiologic findings of the chest, molecular testing (PCR) of a swab specimen, and the appearance of high anti-mycoplasma antibodies in the patient’s serum.

**CONCLUSION**

*M. pneumoniae* is a common pathogen, especially in young adults, and it should be considered on the differential diagnosis of a febrile illness accompanied by LCV, even in the absence of respiratory symptoms. Systemic antibiotic treatment can result in rapid clinical improvement and reduce the chance of extrapulmonary complications.

**References**


Letter to the editor Acta Dermatovenerol Croat 2012;20(2):112-125

Katarina Trčko, Pij Bogomir Marko, Jovan Miljković

Department of Dermatovenereology, University Clinical Center Maribor, Maribor, Slovenia

Corresponding author:

Katarina Trčko, MD

Department of Dermatovenereology

University Clinical Center Maribor

Ljubljanska 5

2000 Maribor

Slovenia

katarina.trcko@gmail.com

Received: October 4, 2011

Accepted: May 15, 2012
Dermatosis Neglecta Presenting as a Brown Verrucous Plaster

INTRODUCTION

The term “dermatosis neglecta” (DN), initially coined in 1995 by Poskitt et al. (1), denotes an acquired, distinctive and bizarre dermatosis resulting from “neglect”, i.e. poor hygiene. The “neglect” might be the result of physical disability, neurologic deficit and/or psychological abnormality, which all preclude adequate cleansing of the affected area (2-4). Therefore, the patient’s “neglect”, which triggers the disorder, is either intentional or subconscious (4-6).

Herein we report a case of DN in the setting of neurologic impairment.

CASE REPORT

A 19-year-old girl presented with a 4-year history of persistent brown scaly and wart-like patches on the right lower leg. Her medical history was notable for right pelvic and femoral osteotomies performed 4 years before because of Legg-Calvé-Perthes disease, which were complicated with sciatic and peroneal nerve palsies. As a consequence, she had limited motility at the hip joint, flexion contracture at the knee joint and foot drop. However, her sole subjective complaint was intense pain elicited when the right lower leg was touched. Therefore, she had been escaping from washing the area during baths and avoiding trimming of the toenails for the past few years.

Dermatological examination revealed brown-gray, sock-like, verrucous plaque involving the right lower leg and right foot. There were islands of normal skin within the main plaque (Fig. 1). Ipsilateral nails were long, thickened, curved and displayed brown-gray discoloration, horizontal grooves and ridges (Fig. 2). Massive plantar hyperkeratosis was evident (Fig. 3). Physical findings on the contralateral leg were completely normal.
The patient started weeping when skin biopsy and alcohol wiping of the affected area were recommended. We were forced to postpone these interventions until after sufficient pain control was attained by appropriate neurologic medications.

**DISCUSSION**

Previously, DN has been reported in the setting of pacemaker insertion, mastectomy, radiotherapy, sunburn, surgical scar, dermatomyositis, hemiplegia, trigeminal neuralgia, stroke, arthritis, keloids, fractures, injuries, immobility, neurologic and psychiatric abnormalities (2-8). The present case exemplifies how severe neurologic impairment may eventuate in the development of DN. The pathogenesis of this phenomenon has been attributed to insufficient exfoliation and progressive accumulation of dirt, sebum, sweat, keratinocytes, debris and bacteria, which form a compact and adherent crust-like artificial layer in a localized “unwashed” area of skin (2-4,7).

Clinically, the disorder is characterized by pigmented “dirty” and scaly patches or verrucous plaques (3,5,9). Lesions have been reported on the eyelids, face, neck, hands, chest, umbilicus, periareolar and pubic areas (2-4,6-9). A history of pain, hyperesthesia, allodynia or paresthesia localized to the affected area because of severe pain. Reassurance may be hardly persuaded for thorough cleansing of the “unwashed” area of skin and nails in a background of neurologic deficit results in repulsive unsightly consequences.

Histopathology in DN displays massive hyperkeratosis and orthokeratosis (4,6-8). Papillomatosis, anastomosis of rete pegs, mild acanthosis, decreased granular layer and sparse perivascular lymphocytic infiltration have also been witnessed (6-8). Numerous Malassezia yeasts have been observed in the stratum corneum, possibly secondary to yeast overgrowth in this appropriate milieu (3,4,8).

Scrubbing the area with soap and water or gently rubbing with alcohol are appropriate measures for getting rid of the ‘dirty’ appearance (2,3,5,7,8). Applying friction with a washcloth simplifies the procedure (8). Wiping with H₂O₂ and saline-soaked pads has also been effective (7). Keratolytics and emollients may be required in verrucous, recurrent or resistant cases (2,3,8).

DN should be considered on the differential diagnosis of all pigmentation and keratinization disorders encountered in dermatological practice. The exhausting list of diagnostic considerations include acanthosis nigricans, confluent and reticulated papillomatosis, pityriasis versicolor, seborrheic keratosis, verrucous nevi, psoriasis, vagabonds’ disease, elephantiasis nostras verrucosa, frictional hyperkeratosis, postinflammatory hyperpigmentation, dermatitis artefacta and terra-firma forme dermatosis (2,3,6,7,9-11). Cleansing, performed by a dermatologist, is a simple procedure that may help discriminate DN and exclude most of its clinical simulates (10). Dermatitis artefacta is regarded as an act of commission, while DN represents an act of omission (3,7). Terra-firma forme dermatosis is arbitrarily distinguished from DN by the presence of adequate hygiene and successful eradication of pigmentation with isopropyl alcohol in the former and with soap and water in the latter (2,3,10,11). However, isopropyl alcohol is operative in both disorders (10,11). Histologically, both disorders display similar features, except for the absence of whorled hyperkeratosis in DN (11). Nevertheless, the distinction between terra-firma forme dermatosis and DN is blurred and there seems to be a considerable overlap between the two disorders.

**CONCLUSION**

Cleansing not only serves as a diagnostic, but also as an easy and fast therapeutic tool in DN (8). However, while some patients may be reluctant to admit that the condition is due to negligence (3), others may be hardly persuaded for thorough cleansing of the affected area because of severe pain. Reassurance may be sufficient in troublesome cases.

**References**

6. Park JM, Roh MR, Kwon JE, Lee KY, Yoon TY, Lee MG, Kim HJ. A case of generalized dermatitis...


Emel Erkek, Engin Sezer
Acıbadem University School of Medicine, Istanbul, Turkey

Corresponding author:
Prof. Emel Erkek, MD,
Acıbadem Maslak Hospital
Büyükdere Caddesi 40
Maslak 34457
İstanbul
Turkey
emelerkek@yahoo.com

Received: October 21, 2011
Accepted: March 8, 2012