

without any improvement in symptoms. Two patients tested positive for antinuclear antibodies and 1 of these, diagnosed with systemic lupus, also tested positive for anti-Ro antibodies.

Of all the patients treated, only 3 showed a mild improvement. The remaining patients showed no response to treatment.

In the case series presented here, response was limited, as only 3 out of 10 patients reported a mild improvement in symptoms. Although this study cannot provide definitive conclusions, the results would seem to reject the hypothesis of the usefulness of α -lipoic acid in the treatment of BMS, as indicated in the systematic review published by the Cochrane library in 2005.² Rigorous clinical trials would therefore be needed to demonstrate whether or not this treatment is effective.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Blaschkoid, Zosteriform Linear Lichen Sclerosus et Atrophicus

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To the Editor:

Lichen sclerosus et atrophicus is a chronic inflammatory disease that can affect the genital and perineal area, occurring less frequently in extragenital locations. Blaschkoid or zosteriform linear forms of this dermatosis have rarely been described in the literature. We present a case of lichen sclerosus et atrophicus forming linear lesions of 2 different patterns in the same patient: the first along the Blaschko lines, and the others on top of previous scarring from herpes zoster as the manifestation of an isotopic response.

A 47-year-old man was referred to us for a clinical condition with onset 4 years previously. This consisted of the appearance of slightly pruritic, whitish lesions on an area of atrophic scars on the right-hand side of the

abdomen where the patient had suffered an episode of herpes zoster 7 years previously. Over the last 2 years he had also noted the appearance of similar lesions extending from the right scapular region to the shoulder and the right pectoral zone. He reported no history of previous trauma, autoimmune disease or other relevant issues. Laboratory tests, including autoimmunity screening (antinuclear, anti-DNA, anti-SS-A, anti-SS-B, anti-RNP and anti-Scl-70 antibodies) were normal.

Physical examination revealed the presence of whitish plaques with an atrophic surface, follicular plugs, and erythematous edges in linear formations along the upper right-hand side of the back (Figure 1), as well as more isolated lesions in the area under the clavicle on the right.



Figure 1. Whitish plaques with atrophic surface and violaceous erythematous edges in a linear blaschkoid distribution on the upper right side of the back.



Figure 2. Shiny whitish plaques on underlying scarring with postinflammatory hyperpigmentation in dermatomes D9-D10.

Hypopigmented and indurate plaques were also present on the right-hand side on a depressed area with postinflammatory hyperpigmentation in dermatomes D9-D10—an area where the patient had suffered an episode of herpes zoster 7 years previously (Figure 2). Histopathology of a biopsy extracted from the lesions on the shoulder showed thinning of the epidermis with the loss of the epidermal crests, marked edema in the papillary dermis, more homogenous collagen, and a lymphocytic infiltrate in the middle dermis (Figure 3). Once a diagnosis of lichen sclerosus et atrophicus was confirmed by histopathology, topical treatment with clobetasol propionate 0.05% was prescribed, with a moderate improvement seen in the lesions after a month of treatment.

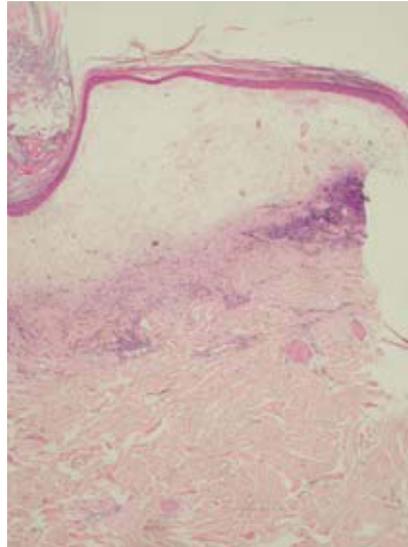


Figure 3. Atrophy of the Malpighian layer with follicular plugs, edema in the papillary dermis, and hyalinization of the collagen with marked inflammatory infiltration (hematoxylin-eosin, $\times 200$).

Lichen sclerosus et atrophicus is a chronic inflammatory disease that usually affects the genital area although extragenital involvement is reported in 15% to 20% of cases.¹ It is most common in adult women, although it can occasionally affect children too.² In our review of the literature we have found 7 cases of lichen sclerosus et atrophicus with a blaschkoid distribution,³⁻⁹ predominantly among women (5:2), with lesions on the trunk,^{3,6} the lower limbs,^{5,7} the face,^{8,9} and the upper limbs.⁴ The blaschkoid linear pattern of inflammatory dermatosis seems to be the consequence of a genetic mosaicism where an abnormal keratinocyte clone remains inactive until an environmental factor stimulates growth leading to segmental clinical manifestations.¹⁰ The existence of mosaicism-related phenomena has been described in more than 15 monogenic skin diseases to date,¹¹ and in various inflammatory cutaneous diseases.^{12,13}

The term "isotopic response," as defined by Wolf et al¹⁴ in 1995, describes the appearance of a new dermatitis in a location previously affected by an unrelated and healed skin disease, mainly on scarring from herpes zoster. Although various forms of dermatitis have been described in this context (granuloma annulare, pseudolymphoma, granulomatous folliculitis, Rosai-Dorfman disease, etc), only 3 such cases of lichen sclerosus et atrophicus have been reported.^{15,16} It has been suggested that the viral particles of herpes zoster remaining in the skin lesion could favor the development of a second dermatosis, but viral DNA has not been isolated in tissue from the lesion in most cases. Alternatively, postinflammatory changes in skin affected by herpes zoster could precipitate the appearance of a second dermatosis, in action similar to the Koebner response.

In conclusion, the association of blaschkoid and zosteriform lichen sclerosus et atrophicus in our patient could be a matter of chance, but the rarity of both processes

suggests the existence of a link between the 2. We think the connection could lie in the existence of an individual genetic predisposition to lichen sclerosis et atrophicus, where greater vulnerability to certain keratinocyte clones and the presence of environmental factors like viral herpes infections, could be responsible for the unusual clinical presentation of the lesions in our patient.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Hyperkeratosis *Lenticularis Perstans*, or Flegel Disease, With Palmoplantar Involvement

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To the Editor:

Hyperkeratosis lenticularis perstans (HLP) is an autosomal dominant or sporadic keratinization disorder that occurs equally in men and women from 40-50 years old.¹ HLP has been described in association with endocrinal changes, and digestive and cutaneous tumors,^{2,3} and is characterized by the presence of small, asymptomatic erythematous papules that leave characteristic punctate bleeding when they become detached. The lesions generally occur symmetrically along the top of the foot and on the legs, appearing more rarely on the arms, forearms, palms, and soles, and even on the oral mucosa.^{4,5} Agreement has yet to be reached on the role of ultraviolet light in pathogenesis.⁶

Histologically, HLP is characterized by orthokeratotic, eosinophilic, and compact hyperkeratosis, hypogranulosis, thinning of the Malpighian layer, vascular dilation, and

band-like lymphocytic infiltrate in the papillary dermis. Immunohistochemical study shows a predominance of CD4+ T cells that is more evident in the early stages of the illness. Many treatment options have been described, although none has proved effective.^{7,8}

We present the case of a 64-year-old man with diabetes who consulted for asymptomatic, brown, hyperkeratotic papules that appeared progressively over the years with no relation to sun exposure. These were mainly located on the top of the feet, legs, arms, and forearms, leaving hemorrhagic pits on detachment (Figure 1). Pits or dimples could be seen on the palms and soles, reminiscent of the unguis pits of psoriasis (Figure 2). There was no family history of the disorder and tests including general biochemistry and thyroid profiling produced normal results. Biopsy of a papule from the top of the foot