sporadically, and presents at birth or in early adolescence as a verrucous rash that can follow the Blaschko or metameric lines.[4] The lesions are typically asymptomatic, and pruritus is very rare.[5] There are currently 2 subtypes that have been described, one localized and the other generalized.[4,6] The localized form is more common; the lesions are distributed unilaterally and are limited to a single limb, usually distally. The generalized form is rarer. It presents with very numerous lesions on more than 1 anatomic region, usually symmetrically, and can affect the trunk.[4,6] The presence of erosions or ulcers, underlying bone abnormalities, and onychodystrophy have been reported very rarely in association with this variant of PQ.[7]

The patients we describe presented lesions that were clinically and histologically compatible with PQ, with a characteristically unilateral pattern of distribution, affecting the upper and lower limbs and the trunk, but not the face. This clinical pattern could therefore be considered to be a clinical variant within the group of generalized PQ.

The most important complication of PQ is malignant transformation of the lesions (mainly to squamous cell carcinoma and, to a lesser degree, to basal cell carcinoma),[8] with frequencies that vary between 7.5% and 19%[9] of cases on long-term follow-up. The lesions that present the highest risk of malignant transformation are large, long-standing lesions of the linear variant.[2]

It has been suggested that allelic loss or overexpression of tumor suppressor gene p53 detected in linear PQ could explain this higher risk of neoplastic transformation.[7,10]

The therapeutic arsenal in PQ is extensive but lacking in efficacy, and the most important aspect in these patients is periodic follow-up for the early detection of malignant change in any of the lesions. Neither of our patients developed a malignant tumor after long-term follow-up.

Correspondence:
Antonio Martorell Calatayud.
C/ San José de la Montaña, puerta 11.
46008 Valencia, Spain.
antmarto@hotmail.com

Conflicts of Interest
The authors declare no conflicts of interest.

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Hair Transplantation in Temporal Triangular Alopecia

F. Jiménez-Acosta and I. Ponce
Clínica Dermatológica Dr. Jiménez Acosta, Las Palmas de Gran Canaria, Spain

To the Editor:

Temporal triangular alopecia (TTA) or congenital triangular alopecia is a rare form of alopecia circumscripta. First described by Saboraud,[1] its most common clinical presentation is that of a round or oval patch of noninflammatory and nonscarring alopecia, typically located in the anterior temporal area. The patch may increase in size with the growth of the child, generally reaching a diameter of 2 to 4 cm. Inspection through a magnifying glass shows the presence of fine vellus hair and an absence of terminal hair.

TTA can be present at birth or can develop between the first few months of life and the age of 6 years. There are rare cases of adult onset,[2] and the current tendency is therefore to

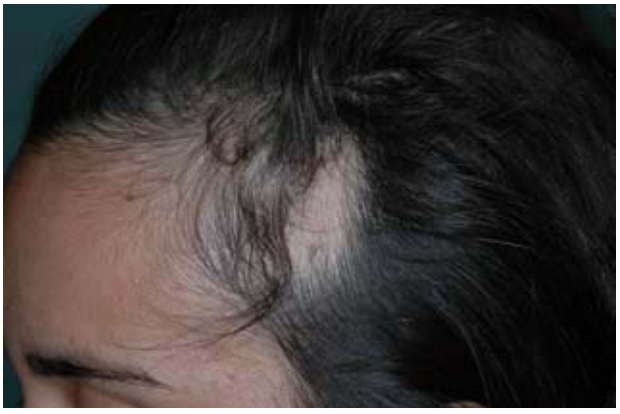

Figure 1. Patient with a bald patch in the left temporal area.

Figure 2. Result 2 years after hair transplantation.

consider it an acquired rather than a congenital condition.[3,4] Although TTA is usually unilateral, about 20% of cases are bilateral.[4] Some rare familial cases have also been reported.[5]

The pathogenesis of TTA is unknown. The fact that TTA develops in the first years of life in an area of the scalp that had previously appeared normal seems to indicate the presence of a localized process of miniaturization of the hair follicles, which produces regression to vellus hair. The stimulus responsible for this irreversible regression is unknown.[6] Histologically, TTA shows hypoplasia of the follicles in a clinically normal scalp. The number of hair follicles is normal, but all are of the vellus (miniaturized) type.[6]

The diagnosis of TTA is clinical: its typical clinical manifestation and location, along with its childhood onset, are sufficient to establish the diagnosis. In doubtful cases, histology makes it possible to distinguish it from other types of alopecia circumscripta, such as epidermal nevi, aplasia cutis congenita,[7] pseudopelade of Brocq, or alopecia areata.

We report a typical case of TTA treated by follicular unit hair transplantation with a satisfactory cosmetic result.

The patient was an 18-year-old woman who came to our clinic for treatment of TTA. She had had a bald patch in the left temporal area since childhood, although she was unable to specify at what age it had appeared. The patch measured 8 cm^2 and was oval in shape (Figure 1).

We performed follicular unit hair transplantation on the bald patch.

The procedure consisted of removing a small strip of skin 4 cm long by 1 cm wide from the occipital scalp (donor area). The surgical wound was closed with 4-0 Ethilon sutures.

From this donor strip a total of 250 follicular units, each containing from 1 to 4 hairs, were dissected using a Zeiss Stemi DV4 stereomicroscope.

These 250 follicular units were implanted into the bald patch under local anesthesia. The 250 incisions (30 incisions per cm^2) made using surgical blades (Personna prep blades) were 0.7 mm in diameter for 1-hair follicular units and 1 mm in diameter for units of 2 to 4 hairs. The 250 follicular units were inserted one by one into these incisions using jeweler-type forceps. The patient was discharged and the stitches in the donor area removed 1 week later. The transplanted grafts began to grow after 3 to 4 months and the patient was extremely satisfied with the cosmetic result (Figure 2).

TTA only requires treatment for cosmetic reasons, as the alopecia is stable and asymptomatic. Medical treatment of TTA with minoxidil or topical or intralesional corticosteroids has not proven effective and surgical treatment is the only therapeutic alternative.[6] Surgery with complete removal of the bald patch is an option to consider, but the closing of surgical wounds 3 to 4 cm in diameter on the scalp may require the use of flaps or tissues expanders. Follicular unit hair transplantation, on the other hand, is a technique that has been used with satisfactory results, not only in male pattern alopecia, but also in other types of cosmetic reconstructions of the scalp.[8,9]

It is interesting to note that there have been hardly any studies published on the usefulness of hair transplantation in TTA, despite the fact that TTA is an indication that is well-known to surgeons specializing in this field. The only case we found was published in 1984 by Bragman,[10] who described the case of a 36-year-old patient with TTA treated with hair grafts obtained using a 4 mm punch. For this reason, we believe it is important for dermatologists to know about the usefulness of hair transplantation in TTA, performed as described in this article, with a satisfactory cosmetic result.

Correspondence:
Francisco Jiménez Acosta.
Clínica Dermatológica Dr. Jiménez Acosta.
Angel Guimerá, 2.
35003 Las Palmas de Gran Canaria, Spain.
fjimenez@clinicadelpelo.com

Conflicts of Interest
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Lichen Planus and Lichen Striatus: Opposite Ends of the Same Spectrum?

F. Pulgar,[a] R. Rivera,[a] J.L. Rodríguez-Peralto,[b] and F. Vanaclocha[a]
[a]Servicio de Dermatología. Servicio de Anatomía Patológica, Hospital Universitario 12 de Octubre, Madrid, Spain

To the Editor:

Lichen planus is an inflammatory dermatosis with an immunological pathogenesis that is not yet fully understood. It is characterized by an eruption consisting of pruritic violaceous polygonal papules that can affect the trunk or limbs and that may often have whitish linear striae, called Wickham striae, on their surface. Involvement of the mucosas is common.[1]

Lichen striatus is an asymptomatic dermatosis that generally occurs in childhood. It consists of small, scaly, erythematous papules of 1 to 2 mm in diameter, occasionally with a vesicular component, distributed in a linear band along the Blaschko lines. The lesions are usually distributed unilaterally on a limb and, unlike those of lichen planus, usually leave a residual hypopigmentation.[1] Bilateral or multiple lesions are very rare.[2,3]

We present a case that started as a linear eruption and subsequently became generalized.

The patient was a 7-year-old girl weighing 20 kg and with a history of celiac decease. She was seen for a pruritic linear eruption that had appeared 3 months earlier on the left upper limb, with involvement of the ipsilateral thumb nail. There was no fever or other clinical symptoms. The condition was diagnosed as lichen striatus, and we prescribed treatment with topical corticosteroids (0.1% methylprednisolone aceponate in a once-daily application).

After a month of topical treatment the lesions were no longer linear and localized, but had spread irregularly over the body. No mucosal lesions were detected. The lesions were shiny violaceous erythematous papules with a lichenoid appearance (Figures 1 and 2) that coalesced to form plaques spread randomly over the trunk, legs, and lumbar region. Some, such as those affecting the antecubital fossae, showed a degree of desquamation.

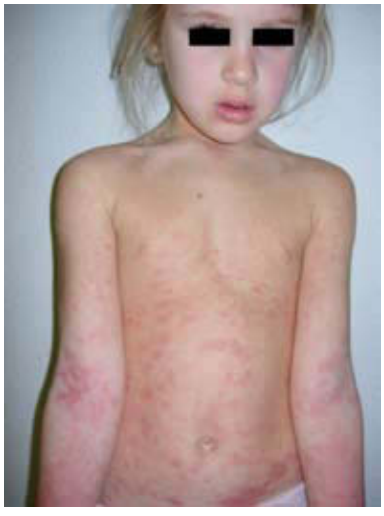

Figure 1. Erythematous violaceous papules with a lichenoid appearance.