



**Figure 4** Cutaneous lesions after 3 months. Residual scarring visible on the leg.

Only 23 cases of extensive cutaneous necrosis linked to APS have been reported in the literature.<sup>1,8</sup> Most of the patients have been young women and the underlying diseases included SLE (9 cases), lupus-like disease (1 case), urinary tract infection (2 cases), acquired immunodeficiency syndrome (1 case), rheumatoid arthritis (1 case), mycosis fungoides (1 case), and mixed connective tissue disease (7 cases). Seven patients had no underlying disease. All of the patients developed thrombotic complications limited to skin, and, as in our patient, the lower limbs were the most commonly affected site. Skin biopsy revealed the presence of thrombi in dermal venules and capillaries, with no evidence of vasculitis.

The mechanisms of thrombosis associated with antiphospholipid antibodies remain unknown.<sup>3</sup> The main entities to take into consideration in the differential diagnosis are catastrophic antiphospholipid antibody syndrome and disseminated intravascular coagulation.

Our patient achieved complete healing with prednisolone at a dose of 1 mg/kg/d and heparin, which was replaced by oral anticoagulants at discharge. At the time of writing, after 1 year of follow-up, there have been no further thrombotic episodes.

We conclude that widespread cutaneous necrosis is a rare initial manifestation of APS and should be considered a

major thrombotic event.<sup>3</sup> It is important to recognize these lesions because early diagnosis enables early treatment, and, possibly, better prognosis.

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## Metastatic Melanoma of the Tongue: A Rare Case

### Melanoma metastásico de la lengua: un caso raro

*To the Editor,*

Cutaneous melanoma is an extremely aggressive malignant tumor arising from melanocytes and accounting some 15% of all cancers. Incidence varies from 3–5 cases per 100 000 inhabitants and year in the Mediterranean region to 12–20

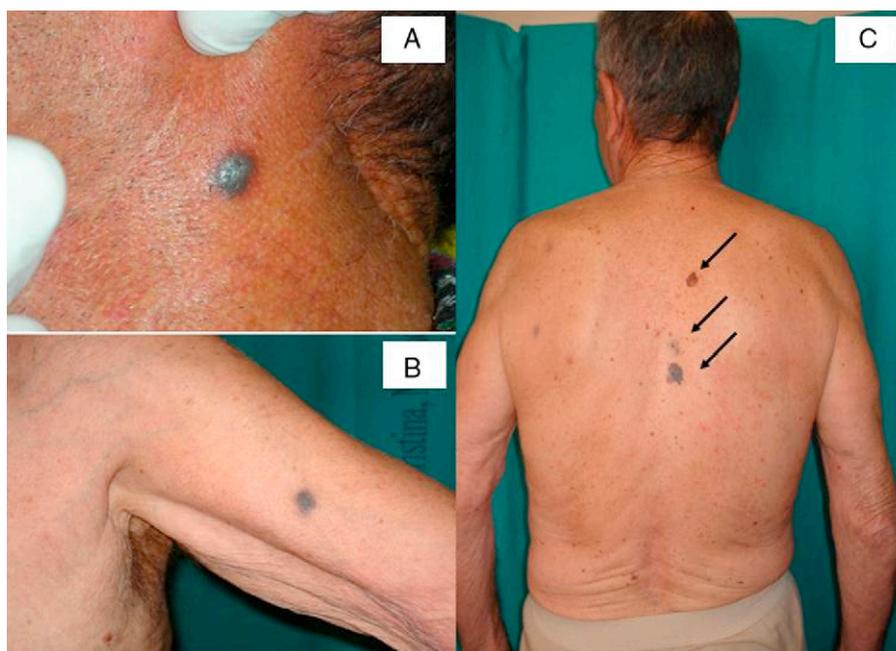
cases per 100 000 inhabitants and year in Nordic countries, and is still increasing worldwide. Cutaneous melanoma is believed to be a cancer that primarily affects white skin, and the risk of developing these tumors is 10 times higher in white-skinned populations than in those with darker skin.<sup>1,2</sup> Melanoma is known for its aggressiveness, and metastases to bones, lungs, brain, liver, or lymph nodes are expected. However, there have been very few reports of oral metastases,<sup>3</sup> which mainly affect the gingiva, tongue, tonsils, and mandible.<sup>4,5</sup>

We describe the case of an 86-year-old white man admitted with a black lesion on the tongue that had persisted for about 2 months. During the consultation, the patient

rejected the idea that he had a disease and complained about the appearance, concurrently with the lingual lesions, of dark nodules on his neck and upper limbs associated with intense and persistent itching, which had on occasion spread to the trunk. These skin lesions had been treated with antihistamines and topical corticosteroids prescribed initially by his family physician and subsequently by a dermatologist, without clinical improvement. Intraoral examination revealed the presence of a wide, irregularly shaped, sepia-black macular lesion that was firm to the touch and asymptomatic, extending from the dorsal to the ventral surface of the tongue. This was associated with small stiff nodules with an ulcerated surface on the left margin and the midline of the anterior third of the tongue (Fig. 1). Extraoral examination (Fig. 2A and B) revealed the presence of blackish oval nodular lesions, palpable and painless, localized to the neck and upper limbs. A diffuse cervical lymphadenopathy was also detected. These clinical findings gave rise to a suspected diagnosis of oral melanoma. While considering it important to establish whether the oral lesions were primary or metastatic, we preferred to start the diagnostic work-up of the suspected melanoma with



**Figure 1** Macular lesion on the dorsum of the tongue associated with small, stiff nodules with an ulcerated-surface located on the left margin and the midline of the anterior third of the tongue.



**Figure 2** (A) and (B) Oval, blackish, palpable, and painless nodular lesions on the neck and upper limbs. (C) Pigmented skin lesions localized on the spinal column and parascapular region (arrows, from the top to the bottom).



**Figure 3** (A) Dermoscopic image of the lesion localized on the spinal column and parascapular region; note the in-transit metastases. (B) and (C) Dermoscopic images of the parascapular brown lesion with regression areas.

an examination of the skin lesions. The results of routine blood tests were within normal limits, with the exception of an increased erythrocyte sedimentation rate. Tests for neoplastic markers revealed the carcino-embryonic antigen. A more detailed clinical and dermoscopic examination of the skin (Fig. 2C) revealed the following findings: *a*) a brown-black variegated pigmented nevus on the spinal column between the shoulders, irregular in shape and color measuring 21 × 16 mm (Fig. 2C, third arrow) and characterized by a blue-gray veil and irregularly shaped globules; the presumptive diagnosis was melanoma with in-transit metastases (Fig. 3A); *b*) 3 pigmented blue-brown lesions (Fig. 2, C, second arrow) situated 14 mm from the first lesion; and *c*) an irregularly shaped variegated brown lesion on the right parascapular region, of 14 × 15 mm (Fig. 2C, first arrow) characterized by a fragmented thickened network and areas of regression, consistent with the diagnosis of melanoma (Fig. 3B and C). Histopathology examination of an incisional biopsy of the parascapular lesion showed a dermis colonized by atypical epithelioid cells indicating a melanoma (Fig. 4). Unexpectedly, after the diagnosis of cutaneous melanoma was confirmed, the patient refused to undergo oral biopsy.

A diagnosis of cutaneous melanoma with oral metastases was confirmed on the basis of the clinical, dermoscopic, and histological data. A chest radiograph demonstrated no active parenchymal lesions.

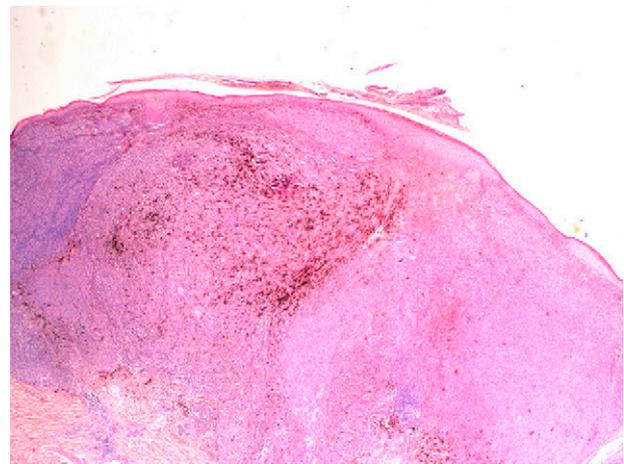
A computed tomography scan of the maxillofacial region, neck, brain, thorax and abdomen revealed no further metastases, but generalized lymphadenopathy. Due to the presence of in-transit metastases, sentinel lymph-node biopsy was not performed, as recently reported.<sup>6</sup>

The patient was referred to an oncology unit, but no therapeutic regimen was undertaken given his age, his refusal to consent to treatment, and the number and extent of his lesions.

Melanoma is a tumor caused by the malignant transformation of melanocytes, a cell line derived from the neuroectoderm. Although the skin continues to be the most frequent site of primary disease (95% of cases), the embryologic origin of melanocytes explains why melanoma is not exclusively a skin cancer.<sup>1</sup> In fact, melanomas may also arise in extracutaneous sites, including the mucosal surfaces of the respiratory, gastrointestinal, and genitourinary tracts and other sites where neural crest cells migrate.<sup>7</sup>

The appearance of a primary melanoma located in the oral cavity is very rare, accounting for only 1–2% of all mucosal melanomas and 0.5% of all oral malignancies; secondary or metastatic forms are even more rare.<sup>3,8</sup> When the maxillofacial region is involved, metastases of cutaneous melanoma are mainly reported in the tongue, tonsils, mandible, gingiva, and parotid glands.

When a patient presents with a pigmented oral lesion, an extraoral clinical examination should be performed; in fact, according to Greene and coworkers,<sup>4,9</sup> in order to consider an oral melanoma as primary, the following 3 criteria must be met: *a*) demonstration of melanoma only in the oral cavity; *b*) presence of junctional activity; and *c*) inability to demonstrate extra-oral primary melanoma.



**Figure 4** Histological features of a biopsied specimen of the parascapular lesion.

In our case, the presence of a cutaneous lesion with a histopathological diagnosis of melanoma allowed us to consider the oral lesions as metastatic.

When analyzing a suspicious skin lesion, it is important to bear in mind the ABCD rule in which A refers to asymmetry, B to border irregularities, C to color heterogeneity, and D to dynamics (in color, elevation, or size).<sup>2</sup> Furthermore, it has been noted, that dermoscopy always enhances the diagnostic accuracy and identifies lesions that must be biopsied,<sup>10</sup> as was the case in this patient.

In conclusion, the appearance of a metastatic lingual melanoma is a very rare event, hence close collaboration among different specialists is very important in case of suspicious pigmented lesions to ensure their early detection and a prompt treatment of such aggressive neoplasm.

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## Comma Hairs: A New Dermoscopic Marker for Tinea Capitis<sup>☆</sup>

### Un nuevo marcador dermatoscópico de tinea capitis: «pelos en coma»

To the Editor:

Dermoscopy is mainly used to analyze pigmented lesions, but in recent years many studies have been published showing the usefulness of this tool in the evaluation of hair and scalp disorders.<sup>1</sup> While most of the studies have focused on the characteristic dermoscopic features of different types of alopecia, in particular alopecia areata and androgenetic alopecia,<sup>1,2</sup> there have been recent reports describing comma hairs as a dermoscopic marker of tinea capitis.<sup>3</sup> Tinea capitis, a dermatophyte infection of the scalp, is still relatively common in routine dermatology practice. It mostly affects children, generally aged between 3 and 7 years,<sup>4</sup> and trichoscopy may therefore be a very useful diagnostic tool in this setting because it is quick, reliable, inexpensive, and noninvasive.<sup>5</sup> We describe 2 patients with tinea capitis and multiple comma hairs as a characteristic dermoscopic finding.

The first patient was a 9-year-old boy with a 10-month history of lesions on the scalp and face. The boy was originally from a village in Bolivia where he had had frequent contact with animals. Physical examination revealed fine whitish scale on the scalp and several plaques of alopecia with marked hair fragility on the hair pull test. The boy also had several erythematous, scaly plaques with irregular but well-defined borders on his face. There were no palpable lymph nodes in the lateral cervical chains. Dermoscopic evaluation of the hair structures showed multiple broken hairs as well as hairs with a characteristic comma-like shape (uniform thickness and color and marked distal angulation) (Fig. 1). Direct examination with potassium hydroxide and microbiological culture confirmed the presence of a zoophilic fungus, identified as *Trichophyton verrucosum*. The patient was administered oral griseofulvin at a dosage of 20 mg/kg/d for 8 weeks. At follow-up 4 months later, the

lesions had cleared completely, and there was no evidence of residual scarring alopecia.

The second case is that of a 2-year-old boy from Senegal who was brought in for evaluation of several plaques of alopecia that had been present on the scalp for 6 months. The hair pull test was positive. On dermoscopic examination, there were multiple hairs with a characteristic comma shape (Fig. 2). Direct examination with potassium hydroxide was positive, but no fungi were isolated in the culture. The condition resolved completely with 8 weeks treatment of oral griseofulvin at 15 mg/kg/d.

Tinea capitis is a common scalp infection in children. It is caused by different dermatophyte species of the genera *Trichophyton* and *Microsporum* and has a prevalence of approximately 1% in developed countries. The condition should be suspected in patients with a single or several small plaques of alopecia accompanied by broken hairs, desquamation, and itching.<sup>4</sup> The differential diagnosis of hair loss in children should include tinea capitis, alopecia areata, traction alopecia, trichotillomania, and loose anagen syndrome, although in this last case, there is generally diffuse hair loss due to traction and an absence of itching and desquamation.<sup>6</sup> Trichoscopy is also a very useful tool in



**Figure 1** Scaling plaque of alopecia in the occipital region. Detail of dermoscopic image showing several comma hairs (in circles) (handheld DermLite II Pro dermoscope and Sony DSC-W55 camera, original magnification  $\times 40$ ).

<sup>☆</sup> Hernández-Bel P, et al. Un nuevo marcador dermatoscópico de tinea capitis: «pelos en coma». *Actas Dermosifiliogr.* 2012;103:837–8.