They are hard to distinguish from each other in clinical practice because of their clinicopathological similarity or overlap. In line with the opinion of Kim et al., we believe that the three disorders are the same disease entity and propose the use of the Latin term ''telangiectasia macularis multiplex acquisita''.[1] In addition, Telangiectasia Macularis Eruptiva Perstans is similar to these entities, but histologically the presence of a mastocyte infiltrate can differentiate them.[1]

Dermoscopy displayed brown pigmentation, linear-irregular vessels, and angioid streak pattern in ABTM, corresponding to basal hyperpigmentation and dermal telangiectasia, respectively. Angioid streak pattern was defined as a central arteriole with superficial radiating small vessels, maybe representing a minor form of spider angioma.[1] The severity and prevalence of angioid streak patterns were higher in ABTM patients with CLD than in those without CLD, but it was absent in our case.[1]

In conclusion, dermoscopy is useful to observe the inconspicuous pigmentation and telangiectasia in ABTM, but the potential value of the angioid streak pattern for the evaluation of underlying CLD remains to be verified. There is no convincing evidence to create several different names for ABT.

Financial support

None declared.

Authors' contributions

Zi-Wei Zhang: Conception and planning of the study; obtaining, analyzing, and interpreting the data; writing of the manuscript.

Hao Wu: Planning of the study; obtaining, analyzing, and interpreting the data; writing of the manuscript.

Ke-Feng Tang: Obtaining, analyzing, and interpreting the data.

Yi-Ming Fan: Conception and planning of the study, obtaining, analyzing, and interpreting the data, critical revision of the manuscript, and approval of its final version.

Conflicts of interest

None declared.

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Received 20 June 2020; accepted 6 August 2020; Available online 27 September 2021

https://doi.org/10.1016/j.abd.2020.08.027

Pigmented poroma on the scalp clinically mimicking basal cell carcinoma☆,☆☆

A 73-year-old Japanese woman visited our department complaining of a nodule on the scalp which had appeared four years previously. Physical examination revealed a 12-mm semi-pedunculated black nodule on the left side of the head (Fig. 1). Dermoscopic examination showed large blue-gray ovoid nest-like structures, irregularly dilated vessels, and erosions. Histopathological examination showed a nodular tumor extending from the epidermis into the mid-dermis (Fig. 2). The tumor was composed of small round cells that had a high nucleocytoplasmic ratio, with small pores, which are features of sweat duct differentiation features of poroid differentiation into small ductal structures (Fig. 3). There were no histopathological features suggestive of basal cell carcinoma (BCC). Some of the tumor cells contained melanin granules, and an increased number of melanocytes, confirmed by HMB-45 staining and MART-1 staining, was observed within the nests. Also, many melanophages were observed in the stroma. After making a diagnosis by punch biopsy, the nodule was removed under local anesthesia.

Eccrine poroma is a benign adnexal tumor mainly composed of poroid cells and often present as a reddish nodule. While eccrine poroma does not appear to have a bias for occurrence between races, pigmented variants

☆ How to cite this article: Ishikawa M, Ohtsuka M, Yamamoto T. Pigmented poroma on the scalp clinically mimicking basal cell carcinoma. An Bras Dermatol. 2021;96:793–5.

☆☆ The study was conducted in Department of Dermatology, Fukushima Medical University, Fukushima, Japan.

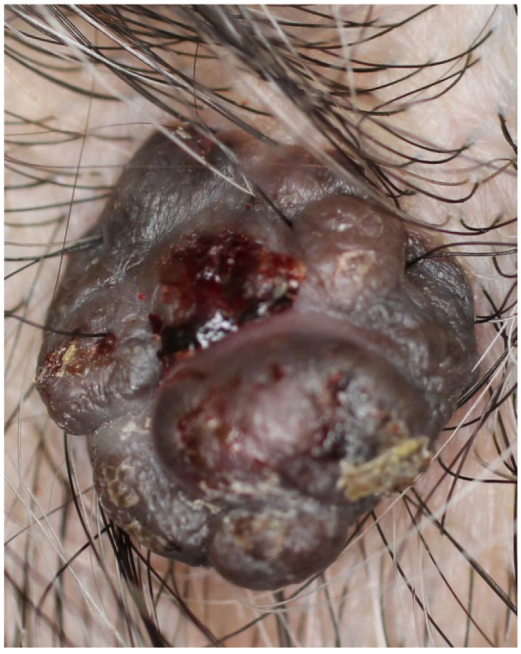

Figure 1 A clinical appearance of semi-pedunculated black nodule on the left side of the head.

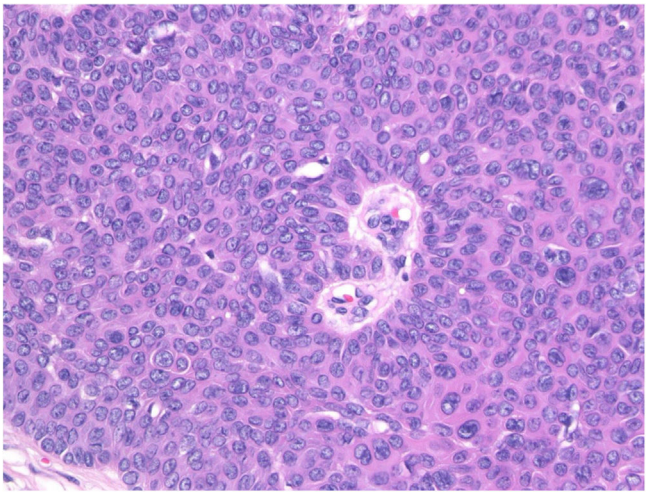

Figure 3 Detail of the histopathological examination: The tumor was composed of small round cells which had a high nucleocytoplasmic ratio, with small pores, which are features of sweat duct differentiations (Hematoxylin-eosin stain, original magnification, 100×).

of eccrine poroma often develop in non-white races. Pigmented eccrine poroma have been reported especially from Japan, and according to a clinicopathological analysis in Japan, among the 421 cases with pathological diagnosis of poroid cell neoplasms, 114 cases (27.1%) had melanin pigment in the tumor cells.[1–3]

As shown in the present case, pigmented eccrine poroma on the scalp can clinically mimic BCC. Previous studies have shown that pigmented eccrine poroma has dermoscopic findings of arborizing vessels and blue-gray ovoid nests, and pigmented eccrine poroma on the face was clinically similar to BCC.[4] In the present case, the gross pathology are similar to those of BCC. In addition, since there were no dermoscopic findings of seborrheic keratosis or malignant melanoma, and the scalp is one of the most frequent areas where BCC occurs, the lesion was suspected to be BCC until the biopsy.

Minagawa and Koga found in their case series study that the most frequent dermoscopic structures in pigmented eccrine poromas were vascular structures such as arborizing vessels, hairpin vessels, and polymorphous vessels.[2] However, the dermoscopic characteristics of other skin tumors such as globule-like structures and comedo-like openings were also found in pigmented eccrine poromas.[2] One possible reason why pigmented eccrine poroma shows similar dermoscopic findings to BCC and/or seborrheic keratosis is that, as both of these tumors are classified into appendage tumors, their rough structures are similar, and they are distinguished only by pathological findings that cannot be observed by dermoscopy. Although Bombonato et al. sug-

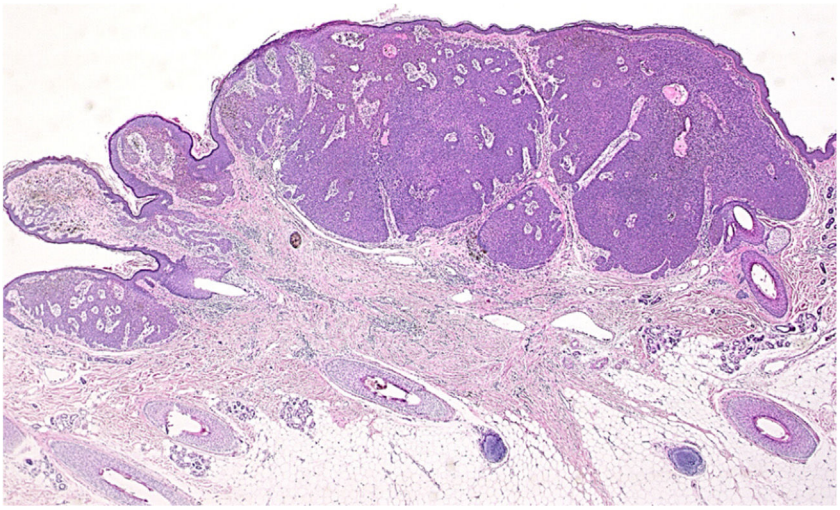

Figure 2 Histopathological examination of the lesion revealed a nodular tumor extending from the epidermis into the mid-dermis (Hematoxylin-eosin stain, original magnification, 20×).

gested that reflectance confocal microscopy may be useful for diagnosing pigmented eccrine poroma, biopsy is still essential for the diagnosis in order to avoid misdiagnosis and overtreatment.[5] In conclusion, considering the lack of established specific dermoscopic criteria for pigmented eccrine poroma, pigmented eccrine poroma on the scalp should be biopsied for histopathologic confirmation of the diagnosis.

Financial support

None.

Authors' contributions

Masato Ishikawa: Designed the study; performed the research and contributed to analysis and interpretation of data; wrote the initial draft of the manuscript; read and approved the final version of the manuscript.

Mikio Ohtsuka: Performed the research and contributed to analysis and interpretation of data; read and approved the final version of the manuscript.

Toshiyuki Yamamoto: Designed the study; assisted in the preparation of the manuscript; read and approved the final version of the manuscript.

Conflicts of interest

None declared.

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Received 15 July 2020; accepted 6 August 2020; Available online 24 September 2021

https://doi.org/10.1016/j.abd.2020.08.028

Safety and efficacy of an interleukin 12/23 inhibitor in a patient with constitutional neutropenia and psoriasis vulgaris☆,☆☆

Dear Editor,

Psoriasis is a chronic, immune-mediated and complex inflammatory disease. The immunopathogenesis of the disease involves interferon-gamma (IFN-gamma), tumor necrosis factor (TNF), and specific interleukins (ILs) that coordinate the interaction between inflammatory cells and keratinocytes.[1]

IL inhibitors represent a new group of biological agents with greater specificity for the treatment of psoriasis, as they selectively target inflammatory pathways.[1]

Ustekinumab is a fully human monoclonal antibody that binds with high affinity and specificity to the p40 protein subunit, shared by cytokines IL-12 and IL-23.[2,3] Its action prevents the binding of IL-12 and IL-23 to their receptor, blocking the Th1 and Th17-mediated inflammatory pathways.[3,4]

Benign constitutional neutropenia is an asymptomatic condition characterized by mild chronic neutropenia (neutrophil count < 1500/mm^3) in patients with no history of recurrent infections and no secondary causes.[5] As these patients are susceptible to infections, the use of immunobiological agents in this population may require special care regarding their safety. There are no reports in the literature on the use and safety of IL-12 and IL-23 inhibitors in these patients.

A 44-year-old dark-skinned male patient started follow-up at a dermatology referral service 10 years ago due to severe psoriasis, without joint involvement. He had a previous diagnosis of familial constitutional leukopenia 17 years ago, with a mean leukocyte count of 2600 mm^3

☆ How to cite this article: Starek JV, Bechara CSR, Dultra MRR, Krakheche JM. Safety and efficacy of an interleukin 12/23 inhibitor in a patient with constitutional neutropenia and psoriasis vulgaris. An Bras Dermatol. 2021;96:795–7.

☆☆ Study conducted at the Complexo Hospitalar Padre Bento de Guarulhos, Guarulhos, SP, Brazil.