Secondary Anetoderma in People with Down's Syndrome

Sir ,

Individuals affected by Down's syndrome sometimes show peculiar dermatoses; some of them, such as palpebral syringomas (1), seem to occur with a particular frequency in this population, others, less frequent, are however characteristic of Down's syndrome, e.g. elastosis perforans serpiginosa (2) and milia-like idiopathic calcinosis (3). We report here on 4 patients with Down's syndrome and anetoderma secondary to folliculitis.

CASE REPORTS

Four adult males, aged 23, 24, 26, and 27 years, affected by Down's syndrome (diagnosis confirmed by karyotyping), were referred to us in the last 2 years because of chronic diffused folliculitis on the trunk, buttocks and lower limbs. These patients presented the classic papulo-pustular elements and, additional, several atrophic, pink or whitish scars (Fig. 1). Pressure with a fingertip revealed the underlying dermal defect.

Histological examination of atrophic lesions from 2 patients (Weigert Van Gieson stain) showed normal epidermis and reduced and fragmented elastic fibres in the dermis.

This result allowed us to diagnose anetoderma secondary to folliculitis. Antibiotic treatment with minocycline (100 mg/day), associated with local zinc-erythrocine lotion, was started and maintained for 1 month and was followed by an excellent healing of the papular-pustular lesions.

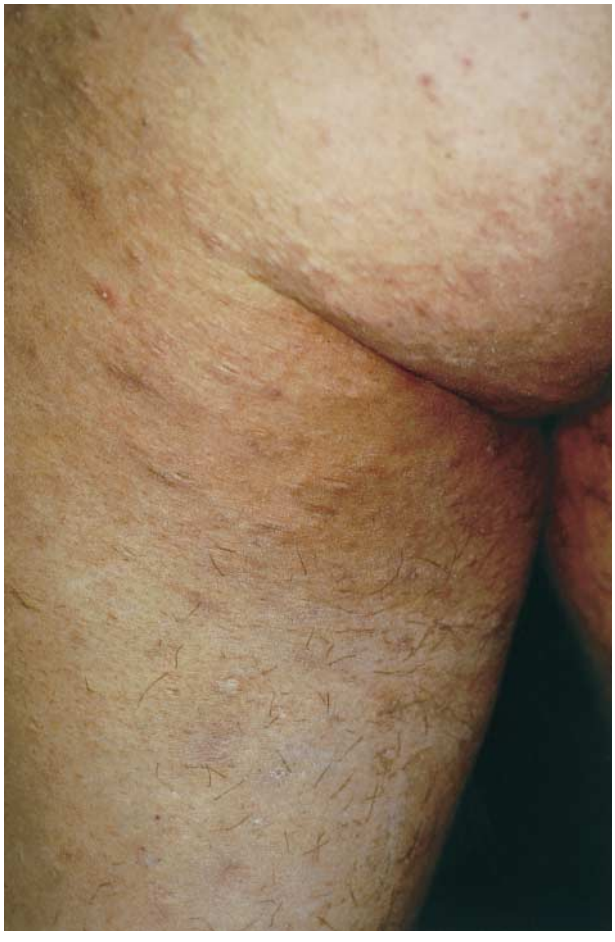

Fig. 1. Lenticular lesions over the thigh.

DISCUSSION

Anetoderma consists of a small rounded atrophic and often hypochromic lesion on the skin, which are easily depressed and histologically characterized by lack of elastic fibres. At present, anetodermas are classified into primary and secondary forms (4). Primary anetoderma comprises the Schweninger Buzzi type, the Jadassohn type and the Pellizzari type. Secondary forms precede or accompany other diseases, such as syphilis, leprosy and acne, and can be induced by drugs such as penicillamine, or are perifollicular (4).

To date, only Kaplan et al. (5) in 1982 have described Down's syndrome patients affected by anetoderma, and they hypothesized a congenital malformation of the elastic fibres in this population. In 1976 Dick et al. (6), in their clinical and experimental study on anetoderma-like scars in patients with acne vulgaris not affected by Down's syndrome, excluded the possiblity that the elastolytic activity was produced by bacteria such as *Staphilococcus epidermisis* or *Propionibacterium acnes* and suggested that elastolysis could be induced by elastases from leukocytes during the inflammatory stage of the disease.

However, we believe that Down's syndrome in the adult population might be considered as predisposed for such a succession and suggest that chronic folliculitis in these patients, not a rare phenomenon in our experience, should be treated with antibiotic systemic therapy, which also avoids the anetoderma-like scars.

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