Halo Eczema in Melanocytic Nevi

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A case of halo eczema in melanocytic nevi is reported. Immunohistochemical techniques using monoclonal antibodies distinguished this condition from halo nevus. The lack of the expression of interleukin 2 receptor by T lymphocytes in the infiltrate suggest that the process is probably different from that of the allergic contact dermatitis. (Received May 15, 1987.)

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The development of an eczematous halo around pigmented nevi is an uncommon clinical and histological variation of nevocellular nevi. Since the original description of "eczematous" changes in melanocytic nevi was reported by Meyerson (1) in 1971, several other cases with similar characteristics have been reported by other authors (2, 3).

This process is characterized by the appearance of erythematous vesicular lesions confined to one or several nevi which become desquamative and clear spontaneously or resolve under topical therapy with corticosteroids. Occasionally, this may be accompanied by similar lesions not associated with nevi. Histopathologically, it is characterized by an inflammatory infiltrate in the superficial dermis in contact with the nevus, spongiosis, exocytosis and epidermal vesiculation (4). All cases reported up to date have shown that nevi persisted unchanged once the lesions had resolved.

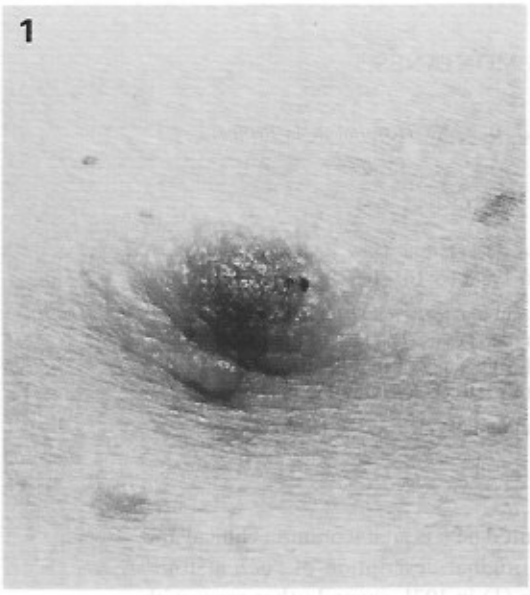
Here, we present a case of halo eczema that has been characterized by immunohistochemical techniques using monoclonal antibodies directed to a distinct T lymphocyte antigens.

CASE REPORT

A 28-year-old man came to the Dermatology Section at the Hospital La Princesa. The patient stated that a few days earlier slightly pruritic erythematous vesicular lesions appeared on his face, trunk and limbs, particularly around pre-existing nevi (Fig. 1). Shortly thereafter, similar less intense lesions appeared in the same areas but were not associated with nevi. These lesions spontaneously cleared in 2 weeks and the nevi remained unchanged. He had no past or family history of atopic disease or contact dermatitis.

A biopsy of the lesion showed moderate, irregular psoriasiform hyperplasia, spongiosis with exocytosis and the formation of small vesicles with plasma in the corneum, associated with focal parakeratosis. Examination of the papillary dermis revealed moderate edema and dense inflammatory infiltrate composed of lymphocytes, histiocytes and eosinophils (Fig. 2). A proliferation of nevi cells in close contact with the dermal infiltrate was observed. These appeared alone or in nests or strands of cells which reached the superficial layer of the reticular dermis with evident signs of maturation. No junctional activity was observed. The lesion which was not associated with the nevus showed spongiotic dermatitis with the formation of vesicles and lymphohistiocytic infiltrate in the superficial dermis.

Monoclonal antibodies specific for T-cell antigens revealed that the inflammatory infiltrate was composed mostly of T-4+ lymphocytes and a reduced number of T-8+ lymphocytes. Staining for T lymphocyte bearing interleukin 2 receptors gave a negative result.



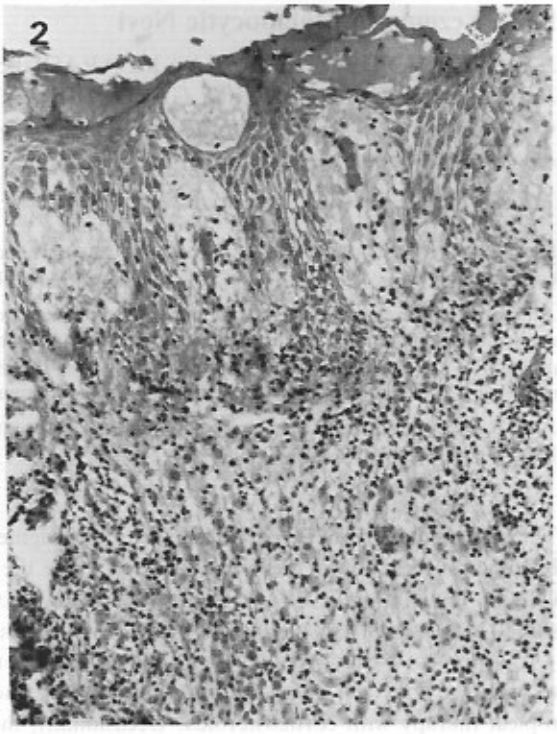


Fig. 1. Erythematous vesicular lesion around nevi.

Fig. 2. Vesiculation, inflammatory infiltrate and nevi cells.

DISCUSSION

Our case is similar to those previously reported in which the involvement of all pre-existing nevi and the appearance of erythematous vesicular lesions were not limited to the nevi.

Meyerson considered this condition as merely an atypical form of pityriasis rosea with a type of Koebner phenomenon concentrating the eruption around nevi and preferred to list the disease as a separate entity (1). However, since the work published by Breenan (3) this condition has been considered as a separate entity from halo nevus based on both clinical and histopathological points of view. The results of our study using monoclonal antibodies clearly distinguishes this condition from halo nevus. In our patient, the T-lymphocytes of the infiltrate were mostly T-4+ as opposed to previous findings where a relatively large number of cytotoxic/suppressor T cells were reported in halo nevus (5).

The exact nature of the spongiotic process still remains obscure. It has been suggested that it could be related to subacute allergic dermatitis (2). However, our results do not agree with this hypothesis, since our results were negative for the expression of interleukin 2 receptor on T lymphocytes present in the infiltrate. From our experience, T lymphocytes bearing interleukin 2 receptor have always been found in the acute phase of allergic contact dermatitis. We believe that the halo eczema in melanocytic nevi is an eczematous disease process with a separate entity, and probably distinct from that of the allergic contact dermatitis.

REFERENCES

1. Meyerson LB. A peculiar papulosquamous eruption involving pigmented nevus. Arch Dermatol 1971; 103: 510–512.
2. Weedon D, Farnsworth J. Spongiotic changes in melanocytic nevi. Am J Dermatopathol 1984; 6, Suppl 1: 257–259.

3. Breenan J, Kossard S, Krivanek J. Halo eczema around melanocytic nevi. Int J Dermatol 1985; 24: 226–229.
4. Weedon D. Unusual features of nevocellular nevi. J Cut Pathol 1982; 9: 284–292.
5. Bergman W, Willemze R, Graaff-Reitsma C, Ruiter DJ. Analysis of major histocompatibility antigens and the mononuclear cell infiltrate in halo nevi. J Invest Dermatol 1985; 85: 25–29.

Familial Multiple Trichodiscomas

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Camarasa JG, Calderon P and Moreno A. Familial Multiple Trichodiscomas. Acta Derm Venereol (Stockh) 1988; 68: 163–165.

A familial multiple trichodiscoma involving two sisters is reported. Trichodiscoma is a benign neoplasm of the mesenchymal component of the hair disk characterized clinically by asymptomatic papules and histologically by a dermal fibrovascular proliferation. Familial involvement and associations with other follicular neoplasia should be investigated in all cases.
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Trichodiscoma was originally described by Pincus et al. (1) as a benign neoplasm of the mesodermal component of the hair disk (*Haarscheibe*). Clinically, trichodiscomas are multiple, smooth, flat or dome-shaped, skin-colored asymptomatic papules. Histologically they appear as slightly elevated fibrovascular papules in a loose connective stroma, rich in acid mucosubstances (1, 2).

In recent publications (3, 4), a new subset of trichodiscomas, involving more than one member of the same family, has been reported. We describe an additional kindred with multiple trichodiscomas.

CASE REPORT

A 40-year-old housewife was referred to our Department for evaluation of cutaneous lesions which had been present for approximately one year.

Dermatological examination revealed multiple, dome-shaped, skin-colored papules, 2 to 3 mm in diameter. They were distributed over the forearms, arms and thighs (Fig. 1). The lesions were asymptomatic. General examination and routine laboratory tests were within normal limits.

The patient had four brothers and three sisters. A sister aged 54 had similar cutaneous lesions located on the thorax and upper extremities that had been present for years.

Two punch biopsies were performed. Histopathological examination revealed a dermal papule (Fig. 2) covered by normal epidermis that showed elongated rete ridges at the periphery, forming a collaret. The papule consisted of spindle-shaped or stellate fibroblasts and haphazardly arranged capillary vessels, embedded in a loose connective stroma (Fig. 3). Colloidal iron (Mowry) stain revealed abundant acid mucopolysaccharides. One of the tumors showed a hair follicle on the rim of the papule.

DISCUSSION

This report presents the third case of familial multiple trichodiscoma. Starink et al. (3) described two sisters and the son of one of them, with multiple trichodiscomas of early onset.