Reticulate Hyperpigmentation of Iijima, Naito and Uyeno

A European Case

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A 15-year-old girl is presented with symmetric, hyperpigmented streaks and whorls on trunk and extremities. The pigmentation is located in the basal layer of the epidermis. The clinical and histopathological picture seems to be identical to the reticulate hyperpigmentation of Iijima, Naito and Uyeno, hitherto only described from Japan. ***Key word: Epidermal melanosis.***

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Iijima, Naito and Uyeno have reported two cases of "reticulate hyperpigmentation distributed in a zosteriform fashion, a new clinical type of hyperpigmentation" (1). The patients were little girls; 4 months and 5 years of age, respectively. The younger one had since 2½ months numerous light brown pigmented spots, 1–2 mm sized, gradually spreading on her body except for the face, palms and soles. The spots formed by coalescence areas of hyperpigmentation in a linear and zosteriform distribution. The elder girl had 2–3 mm sized light brown spots, beginning at the age of 2 years, on the inside of both lower legs, gradually spreading to thighs, dorsa of the hands and finally to the abdomen. In neither case were family members affected. Eosinophils were increased 13% and 17%, respectively. Examination of skeleton and eyes showed no abnormalities. Histopathological examination showed increased basal pigmentation, but no increase of melanocytes and no pigmentary incontinence.

The authors compared their two cases with two other cases previously reported in the Japanese Journal of Dermatology in the Japanese language. The age of onset, the size of the spots, their colour, distribution, slight eosinophilia and histopathological findings were the same. However, the spots were described as depressed.

Progressive cribriform and zosteriform hyperpigmentation (PCZH), as described by Rower et al. (2) is somewhat similar to the four Japanese cases. The age of onset in these 5 cases was higher; 10–18 years. Hyperpigmented spots, coalescing into a zosteriform arrangement, were seen only on the torso or thighs and limited to one dermatome. Histopathological findings were similar to the Japanese cases.

Iijima et al. consider reticulate hyperpigmentation distributed in a zosteriform fashion to be a generalization of PCZH.

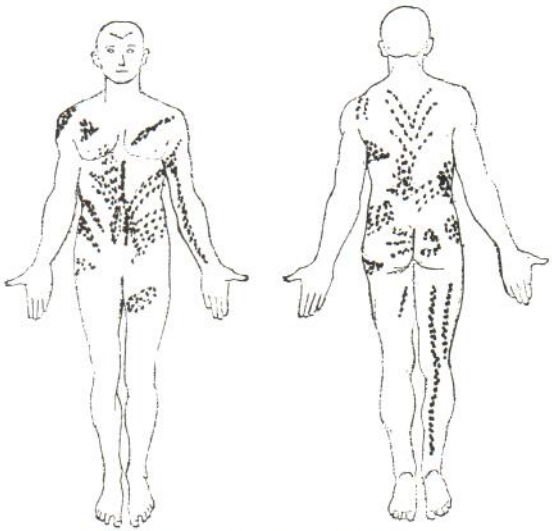

Fig. 1. Distribution of pigmentation in our case.

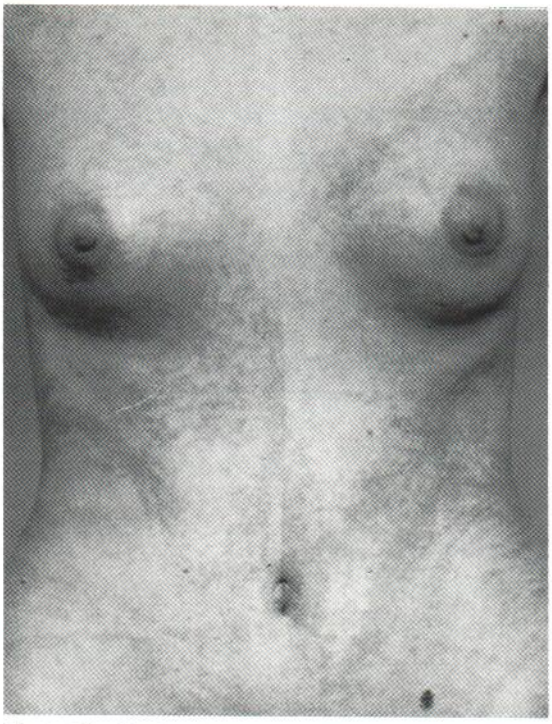

Fig. 2. Distribution of pigmentation on the anterior aspect of the trunk. Naevus spilus on the lower left of the abdomen.

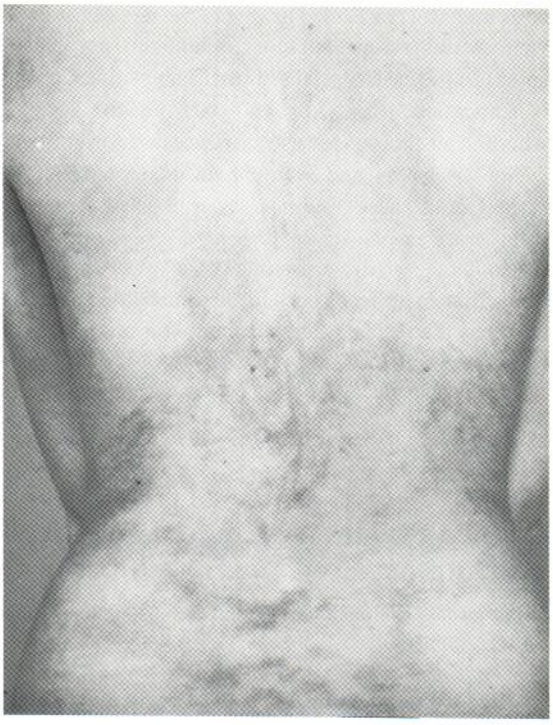

Fig. 3. Distribution of pigmentation on the dorsal aspect of the trunk.

CASE REPORT

A Caucasian girl was born 1972, healthy and of normal weight after an uncomplicated pregnancy. Her skin was normal. No blisters, papules, erythema or pigmented lesions were seen, except for a 7x10 mm naevus on her abdomen. It was diagnosed as naevus spilus (3). At the age of 3 years a woolly hair naevus (4) was observed on the right side of the scalp forming a couple of 2–3 cm patches.

In October 1987 she was referred to the Department of Dermatology in Malmö because of mild acne. Hyperpigmentation of several parts of her body was revealed. She claimed that she had discovered it two years before, while taking a shower. She had no previous symptoms or signs, no change in shape, arrangement or distribution. She did not remember having used any drugs, ointments or cosmetics before onset. She had not exposed herself to the sun before or after the discovery. There was no pigmentary disturbance in the family, or any history of woolly hair, atopy or other diseases of the skin. The skin changes were light brown spots sized 2–3 mm, irregular in shape with clearly defined borders. They were coalescing to streaks and whorls symmetrically on the trunk, arms and legs (Figs. 1–3).

Histopathological examination revealed a normal epidermis. At the base of the rete ridges, the cells showed an increase of granular pigment in the cytoplasm, but no increase of melanocytes. No melanophages were seen in the corium. Blood-ESR, Hb, leukocytes and eosinophils were normal. As she had not exposed herself to the sun, it is not known whether the lesions will be affected by it or not. The clinical course is hitherto unchanged. No treatment has been given.

DISCUSSION

In our case the shape of the pigmented spots, the arrangement and distribution of the symmetric streaks and whorls, as well as the histopathological findings correspond to the cases of Iijama et al. One of their cases also had a naevus spilus. As in their cases, there has been no inflammatory stage and no pigmentary incontinence, thereby excluding incontinentia pigmenti. Otherwise the distribution of the pigmentation with whorls and streaks resembles that disease. There are no neurofibromas or depigmented macules suggesting Morbus Recklinghausen, nor amyloid deposits indicating macular amyloidosis. The distribution of pigmentation was neither depressed nor acral as in acral reticular hyperpigmentation of Kitamura (5).

The lack of epidermal hyperplasia, both clinically and histologically, excludes epidermal naevi including ichthyosis hystrix and inflammatory linear verru-

cous naevus (ILVEN). However, the age of onset as well as the absence of eosinophilia do not correspond to the cases described by Iijima et al. Our case is Caucasian. It is not known from the article, whether all their cases were of Japanese origin.

Naevus spilus and wooly hair naevus are quite rare. Could these findings, as well as the naevus spilus even in one of the Japanese cases, only be a coincidence, or are they part of a syndrome? We think that in spite of certain dissimilarities, our patient has the reticulate hyperpigmentation described by Iijima et al.

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