GDML was described for the first time by Miescher and Leder in 1948. The authors illustrated great clinical similarities of this entity with LN, a chronic disease of unknown origin but that presented distinct histopathological characteristics.[2]

By contrast, other authors, such as Ringrose *et al*.,[4] believed that GDML was a non-diabetic variant of LN. Later, however, it was shown that many of the GDML patients were in fact pre-diabetics or presented change in their glucose curves, proving that both co-morbidities can be concomitant.[1]

The etiology, of both LN and GDML, is still rather unknown. It is believed that changes in the small blood vessels of the skin and hypodermis are important in their pathogeneses, and that habits, like smoking, can worsen vascular damage or even precipitate the clinical manifestation of the disease. The amount of smoking and the beginning of the smoking habit are important risk factors for the development of GDML. Other factors include venous stasis, genetic predisposition, and trauma.[4]

Clinically, GDML can also be confused with LN. The lesions are normally bilateral and symmetric on the anterior surface of the lower and upper limbs, slightly yellow, of a firm consistency, of a translucent and shiny surface, with a discretely atrophic center and subtly raised edges.[1,2,3]

From the histopathological point of view, GDML joins the following aspects that differentiate it from LN. First, the intense participation of the hypodermis can be observed in specific cases, together with a larger quantity of plasmocytes in the site; a minimal degree of necrobiosis; an area of hyalinization of collagen; and the absence or lack of mucin deposits. By contrast, in the LM, one can almost always observe the presence of "palisading granulomas" with necrobiosis.[1,2,3]

The treatment for LN and GDML is difficult to determine, as strong topical corticosteroids, systemic corticosteroids, pentoxifylline, puva therapy, mycophenolate mofetil, chloroquine, sulfone, and anti-TNFs can all be used. It is important to highlight that one of the main long-term risks of NL is its transformation in squamous cell carcinoma.[5]

The present case reported on a middle-aged, non-diabetic female patient who had reported the appearance of lesions on her limbs three years three years before. The clinical condition of this case was very similar to that of LN, and the diagnosis of the disease was only able to be confirmed by performing an anatomopathologic exam that was compatible with GDML.

It is important to note that, due to its rarity and its morphological similarity to LN, GDML is subject to being clinically underdiagnosed, and a biopsy should always be performed to confirm a proper histopathological diagnosis. ❑

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How to cite this article: *Oliveira ARFM, Almeidinha YD, Oliveira Filho J, Michalany AO. Granulomatosis disciformis in non-diabetic patient. An Bras Dermatol. 2017;92(3):438-9.*

Erythematous, vesicular, and circinate lesions in a 78-year-old female – benign familial pemphigus*

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DOI: http://dx.doi.org/10.1590/abd1806-4841.20176711

Dear Editor,

Hailey-Hailey disease, also called benign familial pemphigus, is an autosomal dominant disorder caused by mutations in the ATP2C1 gene. Positive family history is detected in two thirds of all cases. The prevalence is 1:50,000 and the incidence of sporadic mutations might be as high as 26%.[1,2] We present a case of a patient who developed benign familial pemphigus in the seventh decade of life without any medical family history.

A 78-year-old white woman with hypertension and dyslipidemia presented with erythematous plaques in the groin with satellite pustules diagnosed as candidal intertrigo. The lesions had presented for 4 months and showed no improvement under topical and oral antifungal treatment (Figure 1). The patient reported severe itching. In two weeks' time, a new perineal erythema appeared with linear erosions and eczematous, circinate lesions with some flaccid vesicles involving her neck, back, and upper and lower extremities (Figure 2). The mucosal membranes were not involved. Blood test

Received on 04.03.2016
Approved by the Advisory Board and accepted for publication on 16.12.2016
* Work performed at Hospital Universitari Sagrat Cor – Grupo Quirónsalud – Barcelona, Spain.
Financial support: None.
Conflict of interests: None.

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results were normal and cultures were negative. A punch biopsy of the perineal lesions was obtained and stained with hematoxylin-eosin and another punch was taken and studied through direct immunofluorescence. Indirect immunofluorescence was negative. Pathology data revealed hyperkeratosis and acanthosis with suprabasal acantholysis, which did not affect adnexal structures and resembled a "dilapidated brick wall" (Figure 3). Dyskeratotic keratinocytes were not observed. Direct immunofluorescence study showed no deposition of immunoreactants. These features were consistent with Hailey-Hailey´s disease.

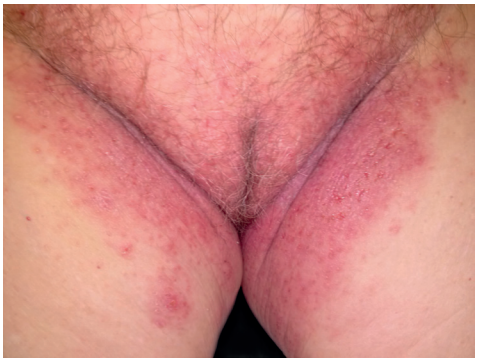

Figure 1: Erythematous plaques with linear erosions

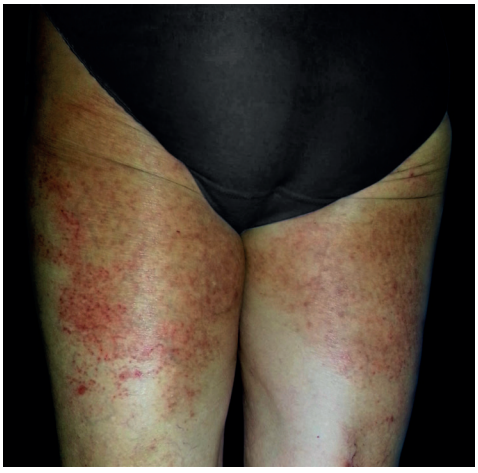

Figure 2: Erythematous plaques and circinate lesions on the lower extremities

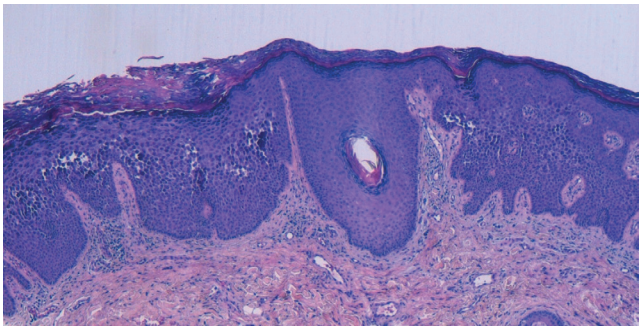

Figure 3: Acanthosis with suprabasal acantholysis. Dyskeratotic keratinocytes are not observed. Hematoxylin and eosin stain

Symptoms include erythematous plaques with blisters and fissures that appear predominantly in skin folds, sometimes with a circinate pattern. Many triggers have been identified (friction, perspiration, ultraviolet radiation). Most patients have worse symptoms during hot summer months when sweat and friction aggravate the eruption. Since the condition usually appears in the third or fourth decade, the onset of clinical manifestations in the seventh decade is uncommon. Lesion infection is the main problem because it causes pain, itching, and an unpleasant smell, with the associated adversity. White bands on the fingernails and pits on the palms can also occur. Dissemination or mucosal involvement is rare.

The diagnosis of Hailey-Hailey disease requires differentiation from other acantholytic dermatoses. Due to the localization of the lesions, differential diagnosis also includes candidal intertrigo, psoriasis inversa, and contact dermatitis. Although herpes simplex infection can mimic the vesicular lesions of Hailey–Hailey disease, Tzanck smear is useful to differentiate the diseases.[3]

There is no first-line treatment. However, wearing light and loose clothes to prevent sweating and friction is an important precaution. The most extended treatment includes topical and systemic antibiotics, topical and systemic corticosteroids, steroidsparing immunomodulators, botulinum toxin injections, retinoids, and dapsone. Although medical treatment is important in the control of disease exacerbations in Hailey-Hailey, many cases are recalcitrant, and medical therapy infrequently leads to prolonged remissions.

Carbon dioxide laser ablation is an option for recalcitrant Hailey-Hailey.[4] If the disease causes extreme disability, surgery can be performed, with the use of grafts and flaps. Oxybutynin is an anti-muscarinic drug that was first associated with the resolution of hyperhidrosis in 1988. In our case, the patient made outstanding progress thanks to the administration of 5 mg/daily of this antiperspirant agent since sweat is one of the precipitating factors of new outbreaks.[5] ❑

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How to cite this article: *Iglesias Plaza A, Iglesias Sancho M, Umbert Millet P, Perez Muñoz N. Erythematous, vesicular, and circinate lesions in a 78-year-old female – benign familial pemphigus. An Bras Dermatol. 2017;92(3):439-40.*