of ''*de novo*'' Langerhans cell histiocytosis and one case of indeterminate cell histiocytosis located in sites previously occupied by a BCC have been described. BCCs can create a cytokine environment that promotes cellular hyperplasia but also facilitates the recruitment of latent HS.[5] Additionally, HS could have induced the development of a BCC at the site of its contiguous skin involvement, but this is unlikely due to the low growth rate of the BCC, compared to HS. Given the rarity of skin involvement in HS, it is necessary to collect more cases to obtain a detailed understanding of its biological behavior.

Financial support

None declared.

Authors' contributions

Inés Gracia-Darder: Approval of the final version of the manuscript; critical literature review; data collection, analysis, and interpretation; effective participation in research orientation; intellectual participation in propaedeutic and/or therapeutic; management of studied cases; manuscript critical review; preparation and writing of the manuscript; statistical analysis; study conception and planning.

Julián Boix-Vilanova: Approval of the final version of the manuscript; data collection, analysis, and interpretation; effective participation in research orientation; intellectual participation in propaedeutic and/or therapeutic; management of studied cases; manuscript critical review.

Cristina Gómez Bellvert: Approval of the final version of the manuscript; data collection, analysis, and interpretation; effective participation in research orientation; manuscript critical review.

Luis Javier Del Pozo Hernando: Approval of the final version of the manuscript; critical literature review; effective participation in research orientation; intellectual participation in propaedeutic and/or therapeutic; management of studied cases; manuscript critical review.

Conflicts of interest

None declared.

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https://doi.org/10.1016/j.abd.2021.02.015

Extensive unilateral nevus comedonicus with an inflammatory component*

Dear Editor,

This case report describes a four-year-old child, followed for three years, with normochromic plaques covered by a cluster of follicular openings filled with keratin, comedo-like, along a large extension of the right side: cervical and retroauricular regions, trunk, buttocks, lower limb and foot.

The lesions were located along the Blaschko's lines (Figs. 1 and 2). Dermoscopy showed more clearly the agminated keratotic plugs (Fig. 3). The lesions were present at birth, and those in the cervical region were often the site of inflammation and secondary infection, requiring recurrent cycles of oral antibiotic therapy during follow-up and surgical removal of the inflamed portion. The child had age-appropriate neuropsychomotor development, with no complaints related to other systems and no family history of relevant diseases. There was no ocular, neurological or skeletal involvement.

Nevus comedonicus is a rare type of epidermal nevus, characterized by a developmental change affecting the pilosebaceous unit. The most frequently affected regions are the face, cervical region, and trunk. It affects both sexes equally, can be congenital, and, in most cases, appears in children before the age of ten.[1] It arouses interest due to the scarcity of cases reported in the literature and the diverse clinical presentations, whether as isolated lesions or extensive cases.

* Study conducted at the Hospital das Clínicas, Universidade Federal de Minas Gerais, Belo Horizonte, MG, Brazil.

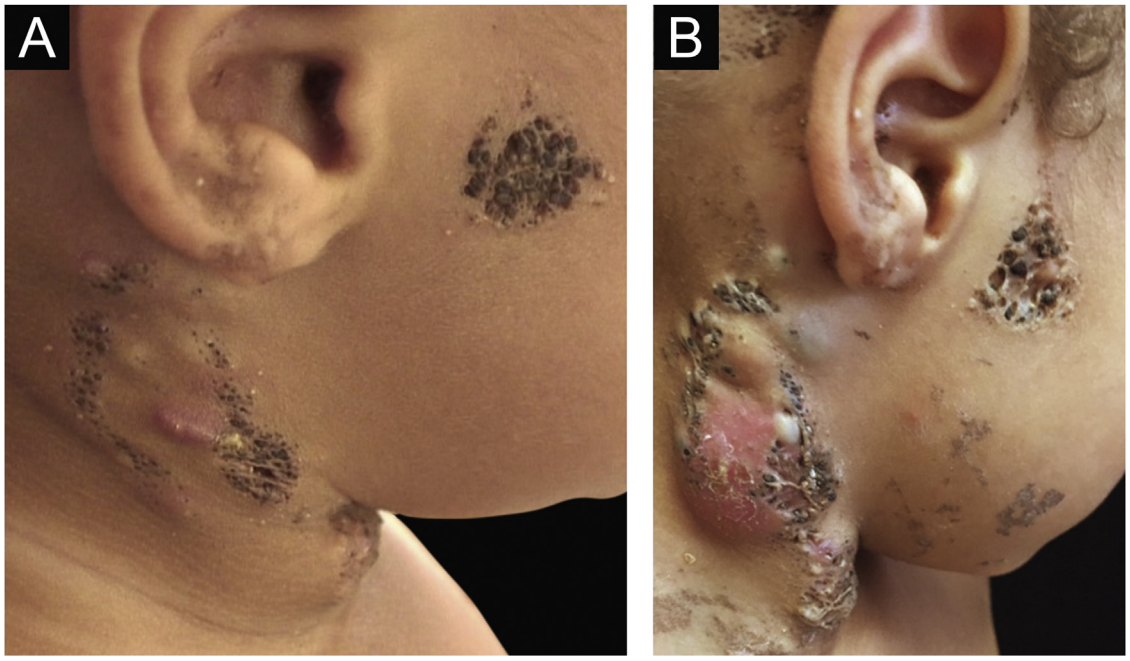

Figure 1 (A) Plaques covered by clusters of comedones, with a small erythematous area and formation of cysts on the right lateral cervical region. (B) Same lesion with worsening of the inflammatory condition.

The first report of nevus comedonicus was presented in 1875 by Kofmann, and a little over 200 cases have been reported in the literature since then.[2] Some authors divide nevi comedonicus into two groups: the non-inflammatory type, consisting of asymptomatic comedonal lesions, with purely aesthetic consequences, and the inflammatory one, which is rarer, more exuberant, with inflammatory cysts and recurrent infections, as the case described here.[3]

The diagnosis of nevus comedonicus is usually a clinical one and may be aided by dermoscopy, especially to differentiate it from other epidermal nevi, such as nevus sebaceous.[1] Histopathology shows dilated and elongated follicular infundibula, with basophilic lamellar corneal content.

This rare hamartomatous condition may be associated with genetic syndromes affecting other systems, and it is important to investigate skeletal, ocular, and central nervous system alterations, which, if present, constitute the nevus comedonicus syndrome.[4] Despite the extent of the lesions in the patient described in the present report, along the lines of Blaschko, which suggested a mosaic pattern, no associated systemic changes were identified.

The treatment can be topical with the use of emollients, corticosteroids in inflammatory lesions, and keratolytic agents. The use of topical tretinoin has been reported, but there is limited data regarding its efficacy.[4] The use of oral isotretinoin has been shown to be ineffective in most patients; however, it may be considered an option in disseminated cases.[3] There have also been some random reports on the use of laser treatment with partial response.[5] Surgery is an excellent option in localized lesions. Although the lesions were extensive in the case described here, affecting the right side of the body, only those located on the cervical region showed inflammation and infection, which prompted surgical approach in this symptomatic and restricted area, with good response.

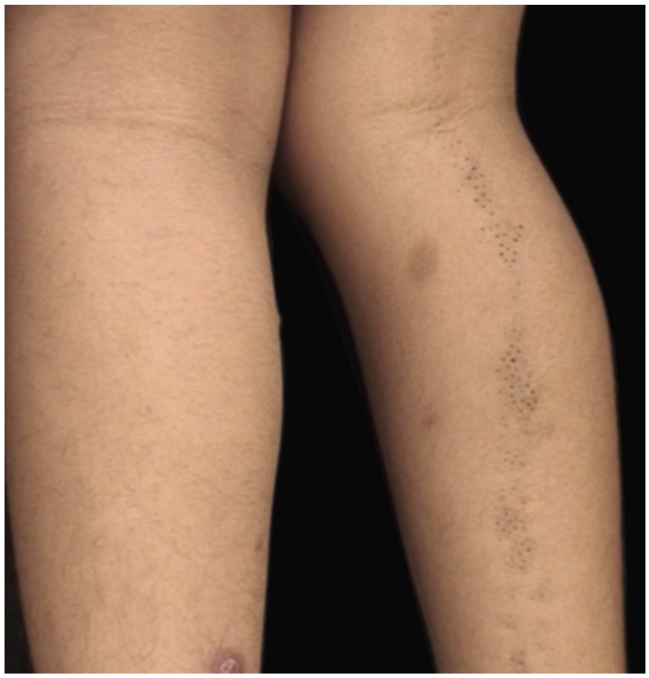

Figure 2 Linear lesion formed by a cluster of comedones following Blaschko's lines on the right lower limb.

Financial support

None declared.

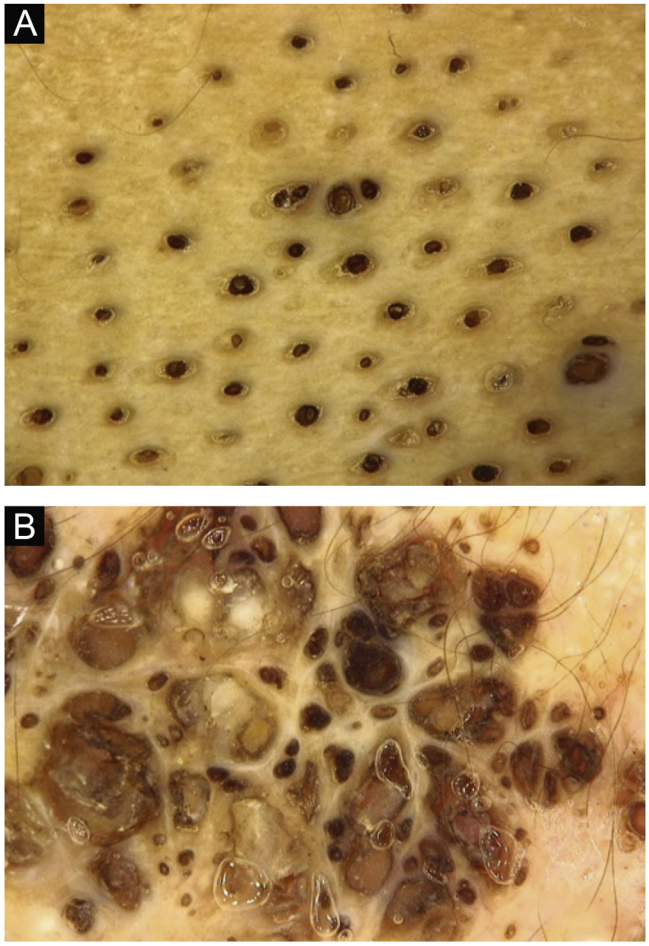

Figure 3 Dermoscopy: dilated follicular openings forming groups of keratinous plugs.

Authors' contributions

Gessica Ramos Barroso Diniz: Collection of data; drafting and editing of the manuscript or critical review of relevant intellectual content; approval of the final version to be submitted.

Flávia Vasques Bittencourt: drafting and editing of the manuscript and critical review of relevant intellectual content; approval of the final version to be submitted.

Conflicts of interest

None declared.

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Received 29 December 2020; accepted 18 January 2021

https://doi.org/10.1016/j.abd.2021.01.012

Genital rash as an initial presentation of monkeypox☆

Dear Editor,

Monkeypox is an endemic disease of Central and Western Africa caused by the Monkeypox virus, a member of the Orthopoxvirus genus. The disease was first diagnosed in humans in 1970 in a baby in Zaire[1] and since then, cases in persons outside Africa have been often linked to international travel or contact with imported animals.[2,3] Recently, an outbreak of monkeypox has occurred worldwide.[4] In the European region, on 22 June 2022, the European Centres for Disease Control identified a total number of 2746 cases from 29 countries, including the Republic of Serbia.[5] Herein, we report a case of monkeypox with genital rash mimicking sexually transmitted infection.

A 35-year-old man was referred to the Department of Sexually Transmitted Infections for the evaluation of a painful genital rash that had appeared five days earlier and was followed by fever. His personal history showed that fever and skin lesions appeared 5 days after unprotected anal intercourse with an unknown male partner in Germany. He had genital herpes in his personal history and no other sexually transmitted infections. Physical examination revealed multiple well-circumscribed deep-seated firm papules with central umbilication on the pubic area and the shaft of the penis. Lesions were relatively the same size and same development stage, surrounded by an erythematous halo, followed by swollen lymph nodes in the groin. Physical

☆ Study conducted at the City Institute for skin and venereal diseases, Belgrade, Serbia.