with multifocal disease involving the right breast and pinna of left ear. As per our knowledge there are only 5 cases of pediatric CRDD without lymph node involvement reported previously and none of them have shown involvement of the pinna as seen in our patient (Table 1).[1-5]

CRDD can mimic histiocytoses, juvenile xanthogranuloma, sarcoidosis, lymphoproliferative disorders, tuberculosis, leishmaniasis and other infiltrative and infectious etiologies. In our patient there was a strong suspicion of lupus vulgaris. However, involvement of the ear aroused suspicion of infiltrative disorders like CRDD at the first visit. Other diseases involving the ear such as pseudolymphoma, leprosy, perichondritis and relapsing polychondritis were clinically ruled out in our case.

Most patients with CRDD have a self-limiting and benign clinical course and spontaneous resolution is frequent. Treatment is required only in symptomatic cases or those with disseminated disease. Corticosteroids, thalidomide, alkylating agents, retinoids, radiotherapy, and surgical excision have been used previously. Although progression to systemic disease has not been reported, nevertheless, follow-up of CRDD patients is recommended to exclude any possible recurrence or subsequent development of systemic disease. ❑

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AUTHORS' CONTRIBUTIONS

Aastha Gupta — ORCID 0000-0002-4057-5365
Preparation and writing of the manuscript

Pooja Arora — ORCID 0000-0002-0718-6990
Approval of the final version of the manuscript, Critical review of the literature

Meenakshi Batrani — ORCID 0000-0002-8539-084X
Collecting, analysis and interpretation of data

Prafulla Kumar Sharma — ORCID 0000-0001-9064-7032
Approval of the final version of the manuscript



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## Multipuncture technique with ingenol mebutate in the treatment of a periungual wart*


Gerson Dellatorre[1]
Anarosa Barbosa Sprenger[1]



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Dear Editor,

Periungual warts (PW) are very common and frequently encountered in the clinical setting. A variety of treatment modalities have been reported, including topical, intralesional, systemic, and surgical approaches.[1] Despite the existence of several treatment approaches, PW are still characterized by their therapeutic resistance.

We report a case of a 37-year-old female patient presenting a recalcitrant PW on her left thumb (Figure 1). Previous treatments included cryotherapy (15 treatments) and imiquimod 5% cream (3 times a week for 8 weeks), without improvement.

We applied ingenol mebutate (IM) gel (Picato®, 0.05%, LeoPharma, Balerup, Denmark) using a multipuncture technique. After skin antisepsis with clorexidine 0.2% solution, IM 0.05% gel was applied over the lesional area (4 x 4mm) and 150 superficial punctures per treatment were made with a 31G needle. The treatments were repeated 3 times at 15-day intervals. Fifteen days after the third procedure, complete resolution was observed (Figure 2). Regarding to adverse effects, only mild desquamation occurred after each application.

IM gel has been effective against human papilloma virus (HPV) lesions, as shown previously in two case series of genital warts, with total lesional clearance in 18 of 19 patients.[2,3] The therapeutic response observed in our case suggests that IM can also be a therapeutic modality in more keratotic HPV-related lesions, such as PW, since drug penetration can be improved by multipuncture technique. ❑


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[1] Department of Dermatology, Hospital Santa Casa de Curitiba, Curitiba (PR), Brazil.

Mailing Address:
Gerson Dellatorre
E-mail: dellatorre@gmail.com

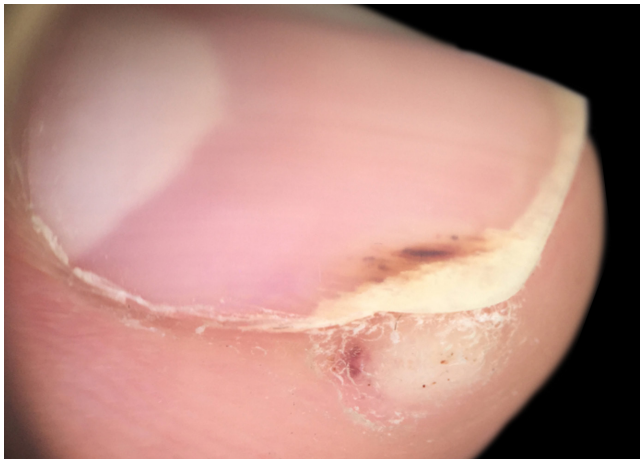

**Figure 1:** Periungual wart. Verrucous lesion on the left thumb with subungual impairment and black dots

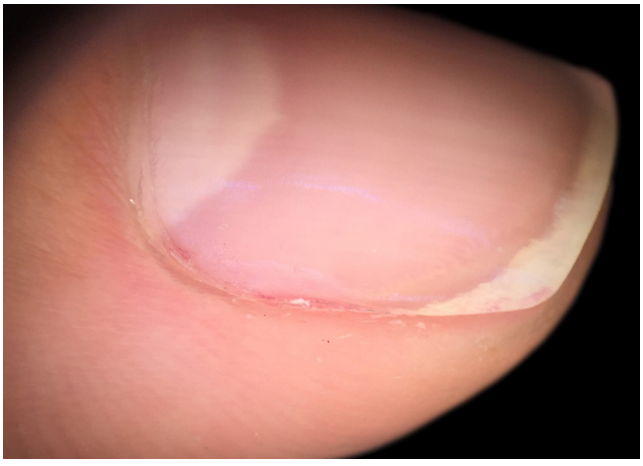

**Figure 2:** Clinical clearance of the lesions 15 days after the third procedure


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AUTHORS' CONTRIBUTIONS

Gerson Dellatorre ORCID 0000-0002-9657-0002

Approval of the final version of the manuscript, Design and planning of the study, Preparation and writing of the manuscript, Intellectual participation in propaedeutic and/or therapeutic conduct of studied cases, Critical review of the literature

Anarosa Barbosa Sprenger ORCID 0000-0002-2282-0195

Approval of the final version of the manuscript, Collecting, analysis and interpretation of data, Effective participation in research orientation, Intellectual participation in propaedeutic and/or therapeutic conduct of studied cases, Critical review of the literature, Critical review of the manuscript



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## Acral persistent papular mucinosis with pruritic skin lesions*


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Ana Iglesias-Plaza[1]
Gemma Melé-Ninot[1]
Noelia Pérez-Muñoz[2]
Montse Salleras-Redonnet[1]


Dear Editor,

Cutaneous mucinoses are a group of diseases in which there is an abnormal deposit of mucin in the skin. It can be classified into primary and secondary forms. An uncommon subtype of primary mucinosis, acral persistent papular mucinosis (APPM) is currently considered as a clinicopathological variant of lichen myxedematosus.

A 31-year-old woman presented a 10-year history of persistent pruritic lesions on her arms. She had no relevant medical history. Physical examination revealed multiple, non-follicular and small (2-5 mm) skin-colored papules, some of them translucent, on the dorsum of both forearms (Figure 1). There were no other similar lesions on the rest of the body. The patient reported that topical corticosteroids were ineffective and sun exposure increased the number of lesions. Laboratory studies were within normal range, including blood cell count, liver, kidney and thyroid function. Antinuclear antibodies were negative. Skin punch biopsy of a papule was performed and histopathological examination showed no alteration in the epidermis. There was a focal area in the upper and mid reticular dermis due to a separation of collagen fibers. Deposit of mucin in the papillary dermis that stained positively with alcian blue was observed. There was no deposit of mucin in the reticular dermis. Fibroblast proliferation was not evident (Figure 2). APPM was then diagnosed.

APPM was first described by Rongioletti *et al.* in 1986[1] and the etiology is unknown, although both genetic and environmental factors are thought to play a role. Rongioletti and Rebora in 2001 proposed several diagnostic criteria for APPM and, to date, there have been more than 30 reported cases of this entity that met the criteria (Table 1).[2] Three cases showed family history.[3] Clinically,


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[1] Department of Dermatology. Hospital Universitari Sagrat Cor, Barcelona, Spain.
[2] Department of Pathology, Hospital Universitari Sagrat Cor, Barcelona, Spain.

Mailing Address:
Ana Iglesias-Plaza
E-mail: anaiglesiasplaza@gmail.com