

## What's Your Dermoscopic Diagnosis?

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### Case Details

*Clinical* - Observe the clinical image of a 40-year old Indian lady who developed gradually progressive asymptomatic dark brown to greyish-blue pigmentation with ill-defined margins involving her forehead, lateral aspect of cheeks, preauricular region extending down till middle neck over the past 3 years. [Fig. 1A]. As a home maker, her sun-exposure was minimal and she denied being very fond of or frequent user of cosmetics and fragrances. She gave history of having used Indian gooseberry (*amla*) oil over her scalp for many years; and had started using an ammonia-free propriety hair color around 4-5 years back. Being unmarried, she did not use vermilion powder in the scalp parting line. There were no other lesions elsewhere, and examination of mucosae, scalp and hair, and nails was unremarkable. No treatment had been sought or taken till now. A patch and photopatch test with the Indian Standard series and cosmetic series revealed 2<sup>+</sup> and 3<sup>+</sup> positive allergic reactions to paraphenylenediamine (PPD) and fragrance mix respectively.

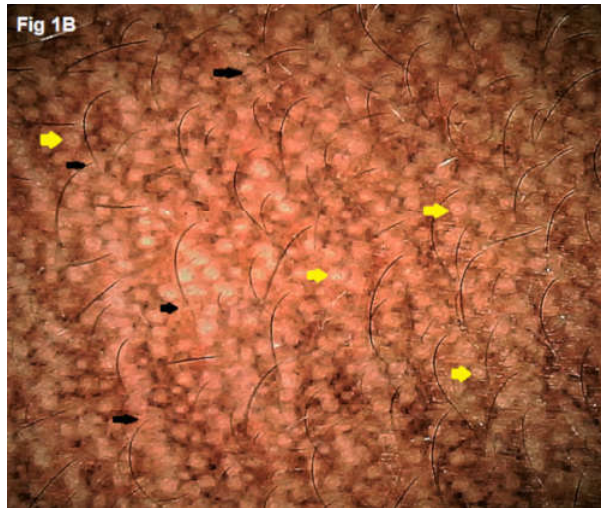
*Dermoscopy* - Dermoscopic image taken from the pre-auricular area (marked with white solid arrow in Fig. 1A) using E-scope

[USB videodermoscope, Timpac Healthcare Pvt. Ltd., New Delhi, India] in polarized mode at 30× magnification is shown in Figure 1B.

### What is the Most Likely Diagnosis?

- (A) Lichen Planus Pigmentosus (LPP)
- (B) Pigmented Contact Dermatitis (Riehl's Melanosis)
- (C) Pigmentary Demarcation Line (PDL)-F
- (D) Nevus of Ota





### Answer

(B) Pigmented Contact Dermatitis (Riehl's Melanosis)

### Comment

Facial melanoses are of diverse etiologies but often have overlapping clinical presentation. Biopsy for histopathological diagnosis is often refused by the patient, especially women owing to the risk and fear of scarring. That's why dermoscopy offers a distinct advantage in non-invasive diagnosis of facial melanoses [1].

The clinical image shows coalescing areas of brown-to-greyish blue hyperpigmentation involving the face and neck, more along the margins suggestive of Riehl's melanosis (RM) as well as LPP as the most likely clinical possibilities. Dermoscopy aided in a relatively more convincing diagnosis of RM. Dermoscopy (**Fig. 1B**) showed an exaggerated pseudo reticular pigmentary network, diffuse brown to faint erythematous background, brown-to-grey colored dots, granules, and globules scattered both discretely and at places accentuated around the eccrine openings, perifollicular whitish halo (*black arrows*), follicular plugs within the hair follicles (*yellow arrows*), and few telangiectatic vessels. These features have been reported to be highly suggestive of RM [2]. Dermoscopic findings of RM and PCD display substantial overlap. However, a more brownish hue of the background, high degree of accentuation of pigmented dots and

globules around the openings of the hair follicles and eccrine glands often arranged in a hem-like, arcuate or reticular pattern, and reduction in the lesional hairs are more typical of LPP. Patch test positivity was earlier considered to be pathognomonic for RM. However, it has been conclusively reported that patch test positivity, e.g. to PPD present in hair color and fragrance mix may also be seen in LPP. PDL-F does not show any specific dermoscopic features, excepting perifollicular and peri-eccrine blotchy brownish areas [3]. Lastly, dermoscopic features of Nevus of Ota and other dermal dendritic melanocytic proliferations remain poorly defined. The description is based along the lines of the blue nevi; characterized by a homogeneous bluish to steel-blue pigmentation [4].

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