infection and suggested that CH represents a specific trichoscopic finding of dermatophytosis of the scalp in the black race.

On the basis of the data reported in the literature, it would therefore seem likely that CH is related to endothrix trichophyton “black dots” TC in black children. However, the same trichoscopic picture was also observed in the Italian white patient described herein. Interestingly, our patient had naturally curly hair, a characteristic more evident in the black population, whose hair tends to be elliptical in cross section with a variable diameter along its shaft that resembles a twisted, oval rod.

In our opinion, the trichoscopic finding of CH seems to be a variation of the comma hair of tinea capitis as described by Slowinska et al, suggesting that it is not a peculiar manifestation in black patients but rather a possible manifestation related to curly hair. Further investigation is needed to confirm our hypothesis.

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In Vivo Gram Staining of Tinea Versicolor

In this report, we demonstrate that tinea versicolor retains topical gentian violet. We did not observe this phenomenon in other hypopigmenting disorders, and thus this observation could be used as a simple bedside test. We call this phenomenon in vivo Gram staining.

Report of a Case | Gentian violet is a commonly used topical anti-infective that has efficacy against gram-positive bacteria and fungi. Given that gentian violet has a long track record in human skin disease, we routinely use it in the treatment of gram-positive cutaneous infections and fungal infections. We present a case of a patient who has been previously diagnosed with tinea versicolor and treated with topical therapy who noted persistence of lesions (Figure, A). We applied gentian violet to his skin and noted a dramatic accentuation of infected areas compared with unaffected skin (Figure, B). Confirmation of infection was made with potassium hydroxide preparation (Figure, C). We have named this phenomenon in vivo Gram staining.

Discussion | Gram stain is used to categorized bacteria into gram-positive and gram-negative organisms. The basic mechanism of Gram staining is the retention of crystal violet, which is another name for gentian violet. Gram-positive bacteria and fungi retain gentian violet in the presence of an alcohol wash, while gram-negative bacteria do not retain gentian violet because the compound does not penetrate the cell wall of gram-negative bacteria. The retention of gentian violet is likely due to the formation of an adduct, which is resistant to decolorization. Recently, our research group demonstrated that gentian violet forms a covalent adduct with thioredoxin reductase 2, a highly conserved protein from bacteria to humans, and is likely a candidate for the retention of gentian violet by the fungus. An additional explanation for selective dye retention is alterations in either host or fungal lipids. Unaffected skin does stain with gentian violet, but the affected areas stain more intensely.

This observation can serve as a potential bedside diagnostic test because other conditions, such as pityriasis rosea, atopic
dermatitis, and vitiligo do not retain gentian violet. Thus, in vivo Gram staining has potential to be a rapid diagnostic test, especially given the prevalence of tinea versicolor in the developing world, as well as a potential therapeutic agent. Further studies of the antifungal activity of gentian violet are indicated.

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Successful Treatment of Rosai–Dorfman Disease With Low-Dose Oral Thalidomide

Rosai–Dorfman disease (RDD) is a rare idiopathic histiocytic proliferative disorder.1 The skin is the most frequently involved extranodal organ. Nevertheless, primary cutaneous manifestation of RDD (CRDD) without systemic involvement is rare.2 We present herein a case of CRDD showing excellent remission after low-dose oral thalidomide therapy.

Report of a Case | A 43-year-old man (height, 178 cm; weight, 80 kg) was referred to our department for evaluation of a 12-month history of painless, enlarging papules and crusts involving the facial and pectoral areas and upper extremities. The papules were moderately tender and occasionally pruritic (Figure 1A). Findings of physical examination, comprehensive laboratory tests, and whole-body radiography were all within normal limits. Two skin biopsy specimens were taken, one from the right mandibular region and the other from the right upper arm. Histopathologic examination revealed that intact lymphocytes, plasma cells, and even neutrophils were readily found within the cytoplasm of histiocytes (emperipolesis). Immunohistochemically, the histiocytes were positive for S-100, CD68, and CD20 and negative for CD1a, CK, and CD21. Periodic acid–Schiff and Giemsa staining results were negative. Based on the clinical and histopathologic findings, a diagnosis of CRDD was made.

The patient had been treated with 36 mg/d of methylprednisone for 3 months and received 10 fractionated local radiation doses of 2 Gray with a total dose of 20 Gray to the face. One lesion in the neck was intraslesionally injected once with combination betamethasone dipropionate/betamethasone disodium phosphate (Diprospan; Merck Sharp & Dohme [Malaysia] Sdn Bhd).3–4 All treatments failed to demonstrate clinical efficacy. After providing his informed consent, the patient was given oral thalidomide, 50 mg/d for 2 weeks with slight improvement and no significant adverse effects. Therefore, the dose of thalidomide was increased to 100 mg/d. After 8 months of treatment, the nodules on his face and limbs had nearly re-