solved, and most of the erythematous plaques had lightened and partially cleared (Figure 1B). At 2-year follow-up, the lesions had not recurred.

Discussion | Various treatment options, including administration of high-dose thalidomide, steroids, chemotherapy, or surgical excision, have been reported with variable success.5–8 Prior to thalidomide treatment, our patient received systemic steroid treatment, local radiotherapy, and an intraleisional injection of steroid in a nodule without clinical improvement. Instead, the lesions progressively enlarged. Our treatment with oral low-dose thalidomide for this benign proliferative disorder resulted in excellent clinical outcome. The most challenging adverse effect of thalidomide is neuropathy, which might be persistent at a cumulative dose of over 20 g.9 Although the cumulative dose of thalidomide was greater than 20 g in our patient, there were no signs of peripheral neuropathy or other adverse effects.

Both successful and failed treatments of RDD with oral thalidomide have been reported,5,6,10 suggesting that there may exist different genetic and etiologic factors in the disease. Those patients with RDD who responded to thalidomide were given doses ranging from 200 to 300 mg/d, and amenorrhea occurred after 3 weeks of treatment (cumulative dose, approximately 6 g).5,10 The present case demonstrates the effectiveness of low-dose oral thalidomide in treatment of CRDD.

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A Dreadful Infestation

Pediculosis humanus capitis, the head louse, is a blood-sucking, obligate parasite that can lead to significant infestation and both direct and indirect medical costs. Treatment can become complicated with outbreaks and increasing resistance.

Report of a Case | A 52-year-old, wheelchair-bound, paraplegic man with a history of pemphigus foliaceus well controlled by azathioprine presented for scalp pruritus. The patient had extensive dreadlocks, which he had grown for decades, since the accident that had paralyzed him (Figure, A). On examination, he also had adherent white nits along his dreadlocks and multiple visibly mobile insects close to his scalp. He was diagnosed with a florid infestation of P humanus capitis (Figure, B).
Several treatment options were presented to our patient but rejected. He attempted home remedies of topical lotions, which were unsuccessful. Our patient adamantly refused to consider cutting his hair and was not amenable to washing or combing of his dreadlocks. The patient further declined oral therapies, concerned about drug-drug interactions and too many medications. Alternative treatment options were considered, and the patient was treated at a local Lice Lifters center (Philadelphia, Pennsylvania) using Louse Buster nonpesticidal therapy (http://www.licelifters.com) with resolution of his infestation and retention of his dreadlocks.

Discussion | Pediculosis humanus capitis is a 6-legged, obligate parasite that can cause persistent pruritus and excoriations secondary to inflammation from the saliva and fecal matter; persistent itching can occur for weeks even after treatment. In addition, infrequent bacterial superinfection can occur, and these lice can rarely serve as a vector for Yersinia pestis or Bartonella quintana.1,2 The female louse lives for 3 to 4 weeks and can lay up to 10 eggs per day; these eggs hatch in 7 to 12 days and then complete their 3 nymph stages before maturing into an adult form. This cycle repeats every 3 weeks.3 Although adult lice typically survive for up to 30 days with blood meals, they cannot live more than 48 hours away from a feeding source.3 Transmission is most common with direct head-to-head contact, although indirect transmission through fomites can occur and is preventable with laundering at high temperatures that kills both the lice and nits.

Ideal therapy for head lice infestation includes ovicidal and pediculocidal topical medications that impact the louse’s nervous system. First-line therapy includes permethrin and pyrethrins, although resistance is becoming increasingly common.4 Older second-line topical therapies also include lindane and malathion, which have safety con-
cerns with flammability and toxic effects, and new topical treatments include benzyl alcohol, spinosad, and ivermectin.5,6 All of these topical treatments require thorough washing of the hair after application and can have adverse effects such as irritant and contact dermatitis if left in place; rare toxic effects also has been reported with application. Oral ivermectin and trimethoprim-sulfamethoxazole are parenteral agents that have been reported to be efficacious in widespread or resistant infestations. Nonpesticidal therapies also include fine-tooth combing; topical application of petrolatum jelly, mayonnaise, or olive oil; meticulous manual removal; or shaving of the head.2

We present a challenging clinical case in an immunosuppressed host complicated by our patient’s extensive infestation involving his dreadlocks. Traditional topical therapies were not possible without washing because of concerns for topical allergic or irritant dermatitis, and physical methods such as combing out the nits and cutting the hair were refused by the patient. Oral medications were considered but also refused. The Lice Lifters physical methods such as combing out the nits and cutting the hair were refused by the patient. Oral medications were considered but also refused. The Lice Lifters center provided a program and combined intensive topical, nontoxic treatments at a local center and at home and manual removal of nits. These techniques should be considered when traditional therapies are not possible.

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Pigmented Basal Cell Carcinoma: Uncommon Presentation in Blue-Eyed Patients

While other subtypes of basal cell carcinoma (BCC) primarily affect individuals with light eyes and hair, fair complexion, and an inability to tan, pigmented BCC has a predilection for darker-skinned populations with dark brown eyes.1-3 Commonly mistaken as melanoma because of its often dark and irregular pigmentation, pigmented BCC is marked by its firm consistency, translucence, and occasional surface ulceration.2 We present 2 cases of pigmented basal cell carcinoma in a fair-skinned patient with blue eyes.

Report of Cases | Patient 1 (Figure, A) is a 75-year-old woman with type I skin, blue eyes, and a history of BCC. She presented with a new pink-brown papule on the back. A biopsy specimen showed masses of basaloid cells within a fibrocellular stroma. Pigment was found both within the tumor cells and in melanophages (Figure, B).

Patient 2 is a 77-year-old man with type I skin and blue eyes and no history of melanoma or nonmelanoma skin cancer. He presented with a brown and pink plaque on the posterior shoulder (Figure, C). A biopsy specimen showed masses of basaloid cells with dense areas of pigment (Figure, D).

Discussion | Pigmented BCC has been very well documented in patients with darker eyes and skin; however, the number of cases reported in lighter-skinned individuals, including those with type I skin, is limited.1,2,4-5 Tan et al5 in 2008 proposed that the predilection for African American, Hispanic, and Asian populations could be owing to the ability to tan along with the greater melanogenic capacity of dark-haired patients. In a study by Bart and Schnall1 in 1973, only 10% of patients with pigmented BCC had light brown eyes, while the eyes of the remaining 90% were dark brown. There were no cases reported in other eye colors. Rossiello and colleagues6 in 2006 described a case of pigmented BCC in a 29-year-old white woman. There have been few cases of pigmented BCC reported in white patients with blue eyes, further supporting an association with darker skin and eye color.7 Differentiating pigmented BCC from melanoma or atypical melanocytic nevi is essential; in our case, the diagnosis was determined by characteristic histologic findings of benign proliferation of melanocytes throughout the basaloïd tumor islands and numerous pigment-laden melanophages within the fibrocellular tumor stroma. Despite the fact that only 7% of BCCs are pigmented,8 and they are uncommon in fair-skinned populations, pigmented BCC should be included in the differential diagnosis of atypical pigmented lesions in patients with lighter skin or eyes.

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