Figure 2. Lesional Biopsy Specimen Obtained From the Left Thigh

The photograph shows a junctional nevus with congenital features (hematoxylin-eosin, original magnification ×200).

skin biopsy specimen from the left posterior thigh showed characteristics consistent with CMN (Figure 2).

Discussion | Poland syndrome, named after the British surgeon Alfred Poland who first described it in 1841, is an uncommon, sporadic, and very rarely inherited birth defect characterized by unilateral chest wall hypoplasia (often right-sided) and ipsilateral hand deformity (most often synbrachydactyly and less often oligodactyly).1 Poland syndrome affects boys 2 to 3 times as often as girls, with an estimated incidence of 1 in 10,000 to 100,000 live births. Its exact cause remains unclear, but a prevailing theory is hypoplasia of the subclavian artery shortly after birth, with an estimated prevalence of 0.5% to 31.7%, or 1 in 3000 to 1 in 30000 newborns.2

Poland syndrome has been associated with hematopoietic malignancies such as leukemia and non-Hodgkin lymphoma, as well as other syndromes, including Möbius syndrome (characterized by congenital bilateral facial paralysis with inability to abduct the eyes) and Klippel-Feil syndrome (characterized by congenital fusion of any 2 of the 7 cervical vertebrae).1 In addition to these known associations, a literature review revealed a few isolated cases of Poland syndrome with various congenital dermatologic findings, including recessive X-linked ichthyosis, congenital hemangioma, and café-au-lait spots.2-4 To our knowledge, the case is the first reported case of Poland syndrome associated with multiple CMN.

A CMN is a benign, clonal proliferation of melanocytes in the epidermal, dermal, or subcutaneous tissue that is present at or shortly after birth, with an estimated prevalence of 0.5% to 31.7%, depending on the study. They are usually solitary, but 3% are multiple, occasionally arranged in a cluster and rarely in a linear distribution. Indeed, only 2 cases of Blaschkolinear CMN have been reported thus far.5,6 Our patient would represent the third such case, and it occurs in a patient with Poland syndrome.

The definite risk of developing melanoma in Blaschkolinear CMN remains unclear because of its rarity. Our patient had no clinical sign of malignant transformation by age 11 years, as in the 2 previously reported cases at age 15 and 28 years. However, long-term close clinical monitoring might be warranted, as in giant CMN.

In summary, we report herein a rare case of Blaschkolinear CMN in a teenager with Poland syndrome. The association between the 2 conditions seems to be coincidental, as in previously reported cases of Poland syndrome with other congenital dermatologic findings.

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Uncommon Presentation of Pityriasis Rosea After Yellow Fever Inoculation

Report of a Case | A man in his 30s was referred for acute onset of pruritic scaly eruptions of the groin, penis, scrotum, and pubic mound. The lesions started to appear 3 weeks prior to presentation with an oval erythematous lesion located around the left thigh. About 7 days after the appearance of the first lesion, others began to appear. The patient reported that 2 weeks before the appearance of the first lesion, he had been inoculated against yellow fever and had an episode of coryza and hacking cough.

The lesions consisted of multiple, coalescent oval plaques of 0.2 cm to 4 cm in longest diameter (Figure) with atypical scales. Other skin areas and mucosal surfaces were unaffected. The findings of general and systemic examinations were normal. Skin scrapings for potassium hydroxide examination, complete blood cell counts, urinalysis, blood glucose assay, VDRL (Venereal Disease Research Laboratory) test, and human immunodeficiency virus antibodies were all normal. The pruritus and eruptions cleared within 6 weeks following treatment with mometasone furoate cream and oral Levocetirizine, 5 mg/d, leaving postinflammatory hyperpigmentation.

Discussion | Pityriasis Rosea (PR) is a self-limiting papulosquamous disorder typically characterized by sudden onset of a larger scaly plaque (herald patch) followed (about 1-2 weeks later) by eruptions of multiple, bilateral, smaller, scaly oval or round lesions that follow the Langer lines of cleavage on the trunk and proximal parts of extremities. Skin lesions usually last about 6 weeks. Current evidence indicates that PR is a type of viral exanthema and the cause may be linked to human herpes virus (HHV)-6 and HHV-7.1
Approximately 20% of patients present with atypical or variant forms of PR, which are less readily recognized than typical eruptions and may pose a diagnostic challenge.2,3 The morphologic characteristics of the eruption may be papular, vesicular, purpuric or hemorrhagic, or urticarial. Very small lesions will be observed in papular PR, and PR with enormous plaques is known as pityriasis rosea gigantea of Darier. A morphologic variant characterized by atypical large patches that tend to be few in number and coalescent has been described.

In this variant, commonly referred to as pityriasis circinata et marginata of Vidal or limb-girdle PR, the eruption generally appears in the axillae, the groin, or both, with the trunk and extremities usually spared.4,5 A simple classification for atypical pityriasis rosea has been proposed by Chuh and Zawar (Box).6

In our patient, the eruption fulfills all 3 essential clinical features (discrete annular lesions, scaling, and peripheral collarette scaling with central clearance on at least 2 lesions), all 3 optional clinical features (relative truncal distribution, orientation along skin cleavage lines, and herald patch), and none of the exclusional clinical features. This case has clinical features of localized PR, papular PR, and pityriasis circinata et marginata of Vidal. It should also be noted that the involvement of penile and scrotal skin is rarely reported in PR. Physicians should be aware of the wide spectrum of PR variants so that appropriate management and reassurance can be offered.

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**Cutaneous Hemophagocytosis After Alemtuzumab Injection in a Patient With Sézary Syndrome**

Alemtuzumab, a CD52 monoclonal antibody, is increasingly used for treating advanced cutaneous T-cell lymphomas including Sézary syndrome (SS). While injection site reactions are common, the finding of localized cutaneous hemophagocytosis at the injection site without systemic hemophagocytosis is rare.

**Report of a Case** | A woman in her 60s presented with a 2-year history of SS (clinical stage IVA [T4NMOB2]). After multiple regimens failed, she was treated with subcutaneous alemtuzumab injections (10 mg each) thrice weekly for 10 weeks and experienced complete remission. However, her disease recurred 7 months after therapy was completed. She restarted treatment with alemtuzumab and 1 month later developed large, tender, indurated plaques on the left lower abdomen and right thigh at her injection sites (Figure, A). Analysis of a right thigh biopsy specimen (Figure, B) showed a deep dermal and subcutaneous