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 depending on the study. They are usually solitary, but 3% are multiple, occasionally arranged in a cluster and rarely in a linear arrangement with an oval erythematous lesion located around the left thigh. About 7 days after the appearance of the first lesion, 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 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 lesions started to appear 3 weeks after 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 lesions started to appear 3 weeks after 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 lesions started to appear 3 weeks after 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.

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

Figure 2. Lesional Biopsy Specimen Obtained From the Left Thigh

The photograph shows a junctional nevus with congenital features (hematoxylin-eosin, original magnification ×200).
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. 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. A simple classification for atypical pityriasis rosea has been proposed by Chuh and Zawar.

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.

Piotr Brzezinski, MD, PhD
Anca Chiriac, MD, PhD

Author Affiliations: Dermatological Clinic, Sixth Military Support Unit, Ustka, Poland (Brzezinski); Department of Dermatology, Nicolina Medical Center, Iasi, Romania (Chiriac).

Corresponding Author: Piotr Brzezinski, MD, PhD, Department of Dermatology, Sixth Military Support Unit, ul Ledowo 1N, 76-270 Ustka, Poland (brzezoo77@yahoo.com).


Conflict of Interest Disclosures: None reported.


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 [T4NMX0B2]). 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