

LETTER TO THE EDITOR

Perifollicular projections in a lentigo maligna of a 35-year-old patient



Proyecciones perifoliculares en un lentigo maligno de una paciente de 35 años

Dear Editor,

A 35-year-old woman presented to her health center with a long-standing pigmented lesion on the left cheek. Clinically, she presented with a dark brown patch with geometric borders measuring approximately 1.5 cm in size (Fig. 1A). Dermoscopically, in addition to multiple colors (dark brown, light brown and reddish tones), perifollicular pigmentation and brown patches, there were multiple perifollicular projections (Fig. 1B). No other mucocutaneous lesions were found on routine examination. On suspicion of malignancy, the patient was referred to dermatology, where a biopsy was performed, confirming the diagnosis of lentigo maligna (LM) (melanoma in situ). Following this diagnosis, Mohs surgery was performed for complete excision of the lesion. At one year follow-up, the patient had no recurrence of the lesion and no new suspicious lesions.

LM is a form of melanoma in situ that usually occurs on chronically sun-exposed areas of the skin, such as the face, in older people. Clinically, it presents as a slow-growing, irregularly bordered, heterogeneous light to dark brown macule or pigmented patch with occasional areas of regression (whitish).¹ Clinical and dermoscopic features are important in differentiating LM from lentigo simplex and lentigo maligna melanoma (LMM). Lentigo simplex, which is benign, typically presents as small, uniformly colored macules that do not change over time. LMM, on the other hand, is a more advanced and aggressive stage of LM in which malignant cells have invaded beyond the epidermis. Clinically, these are usually larger, irregular lesions, sometimes with palpable lesions.² Dermoscopy is an essential tool in the differential diagnosis of LM and pigmented lesions in general. Under dermoscopy, LM shows a number of characteristic patterns.³ A key and distinctive finding of LM is perifollicular projections, which are pigmented structures surrounding the hair follicles that may appear as pseudopods or radial projections. These perifollicular projections are highly suspicious for malignancy and help to differentiate LM from other benign pigmented lesions.^{3,4} In addition to perifollicular projections, other dermoscopic signs of LM include

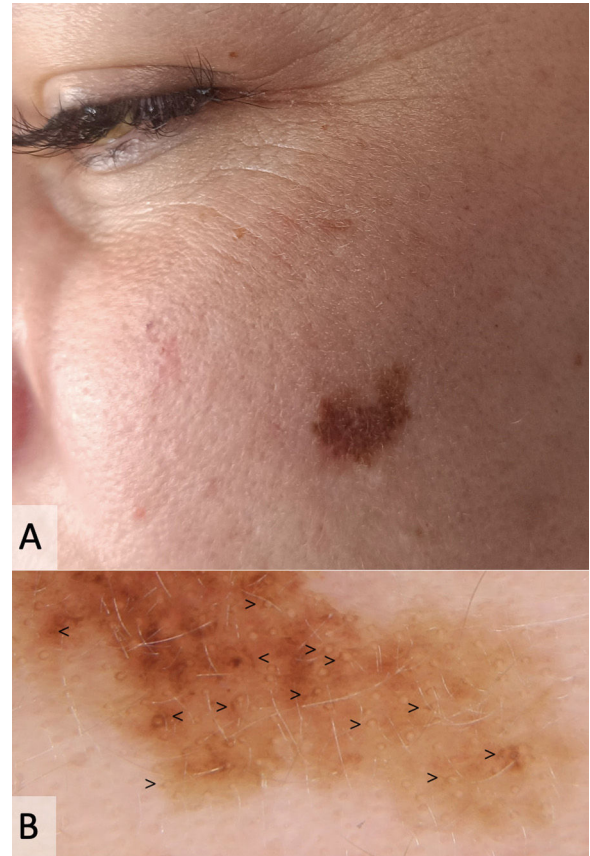


Figure 1 Clinical (A) and dermoscopic (B) presentation of the lesion. Heterogeneous pigmented patch measuring 1.2 cm × 1 cm located on the left cheek. The lesion had an irregular border, multiple colors (dark brown, light brown, and reddish tones), perifollicular pigmentation, and brown dots, as well as multiple perifollicular projections (arrowheads).

an asymmetric pigmented network, areas of regression, and gray or blue dots or globules. The presence of these patterns, together with slow but persistent growth and changes in the pigmentation and borders of the lesion, raise the suspicion of LM. In cases of LM, bluish areas (due to the Tyndall effect, the pigment appears bluish in dermal areas, indicating the depth of the lesion) and raised areas are often seen. An essential lesson of this case, and therefore its peculiarity, is its presence in a young patient. LM in patients under

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the age of 50 is rare. A recent multicenter study showed that they tend to be smaller and have fewer suspicious dermoscopic features, and therefore require a high index of suspicion for diagnosis. Gray color and perifollicular pigmentation may be early dermoscopic findings.⁴ Perifollicular projections have recently been described in LM dermoscopy and may add sensitivity and specificity to the diagnosis, with a high positive predictive value (87%). Perifollicular projections would be present early in the development and progression of LM and should be recognized by every general physician.⁵

In conclusion, LM in young people can be a diagnostic challenge. With this article, we reinforce the idea that the presence of follicular projections on dermoscopy could help in their identification, thus ensuring early diagnosis and treatment before progression to the LM stage.

Authorship

All authors had access to the data and played a role in writing this manuscript.

Author contributions

Miguel Mansilla-Polo and Daniel Morgado-Carrasco managed clinical treatment and procedures, contributing to the development of this paper.

Daniel Morgado-Carrasco supervised the work.

Informed consent

Oral and written consent was obtained to publish these images.

Ethics

Procedures followed here were in accordance with the ethical standards of the responsible committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 1983. We have not used patients' names, initials, or hospital numbers.

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Conflicts of interest

The authors have declared no conflicts of interest.

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