Multiple Grouped Erythematous to Violaceous Preauricular Papules

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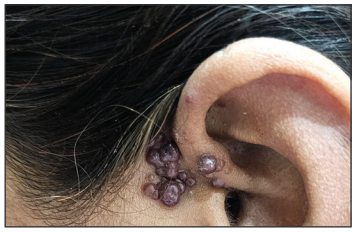
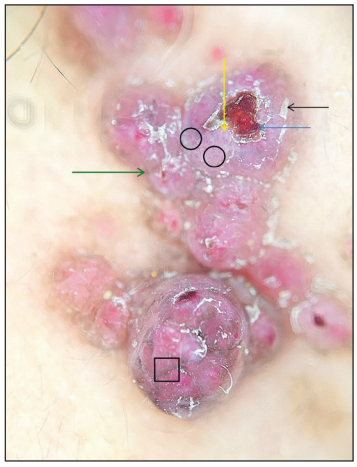
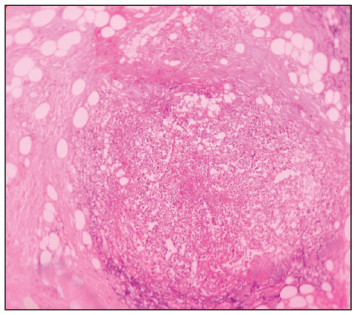




Contact polarized mode, original magnification ×10.



H&E, original magnification ×40.

A 35-year-old woman presented with an insidious onset of multiple grouped erythematous to violaceous papules over the left preauricular area of 3 months' duration (top quiz image). The lesions were soft, itchy, nontender, and friable and were associated with bleeding on excoriation and preauricular lymphadenopathy. Serology for HIV was nonreactive, and Gram staining revealed no bacilli. Laboratory assessment including a complete blood count, urinalysis, and liver and renal function tests was normal.

On dermoscopy (middle quiz image), multiple linear and dotted vessels (circle), reddish lacunae (clods), hemorrhagic crusting (blue arrow), white scaling (black arrow), a brown pigment network (square), white structureless areas (yellow arrow), and white lines were seen over a pale-pink background (green arrow). Scaling and crusting over some lesions, along with a peripheral rim of scaling and brownish pigmentation, also was appreciated. Histopathology revealed a proliferation of vascular channels admixed with lymphocytes, plasma cells, and eosinophils along with a proliferation of thin- and thick-walled blood vessels in the superficial as well as deep dermis (bottom quiz image).

THE BEST **DIAGNOSIS IS:**

a. angiolymphoid hyperplasia with eosinophilia
b. bacillary angiomatosis
c. epithelioid hemangioendothelioma
d. Kimura disease
e. pyogenic granuloma

PLEASE TURN TO PAGE 197 FOR THE DIAGNOSIS

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THE **DIAGNOSIS:** Angiolymphoid Hyperplasia With Eosinophilia

Angiolymphoid hyperplasia with eosinophilia (ALHE) is a rare, benign, inflammatory vascular proliferation with lymphocytic and eosinophilic infiltration. Bleeding and pruritus associated with ALHE can substantially affect a patient's quality of life, necessitating correct diagnosis and effective treatment.[1] The etiopathogenesis of ALHE is poorly understood, and it often is attributed to an underlying vascular malformation or local trauma. Vascular proliferation due to hyperestrogenemia could explain why pregnancy is considered a predisposing factor for ALHE.[1,2]

Angiolymphoid hyperplasia with eosinophilia typically manifests with solitary or multiple pink to red-brown, dome-shaped papules or nodules occurring most frequently on the head and neck. Lesions may be either asymptomatic or associated with pruritus, pain, and spontaneous bleeding.[1] Dermoscopy is crucial to diagnosis. The most frequent dermoscopic findings include a polymorphic vascular pattern such as dotted and linear irregular vessels over a pink background, white lines, white dots, white structureless areas, and red-purple lacunae.[2,3] Histopathology will demonstrate a vascular proliferation with plump epithelioid endothelial cells showing abundant eosinophilic cytoplasm, accompanied by a variable lymphocytic and eosinophilic inflammatory infiltrate (Figure 1).[1]

In our case, dermoscopic-histopathologic correlation suggested that the polymorphic vascular pattern and clods on a pink background corresponded to thin- and thick-walled vessels containing plump endothelial cells and intraluminal erythrocytes within the superficial and deep dermis. White structures could represent underlying fibrosis and altered dermal collagen due to vascular proliferation. The brown pigment network and peripheral brownish pigmentation were most likely secondary to increased melanin and accentuation of the pigment network in the setting of Fitzpatrick skin types IV to V, although pruritic trauma with postinflammatory hyperpigmentation may also have contributed, making dermoscopic-histopathologic correlation challenging.

Surgical excision is considered the primary treatment modality for ALHE, with the lowest recurrence rates.[1] Alternative therapeutic options include intralesional steroids, cryotherapy, sclerotherapy, radiofrequency, pulsed dye laser, and carbon dioxide laser, with varying efficacy reported.[1] Our patient was treated with a combination of a long-pulse Nd:YAG laser (pulse width of 30 ms) to target the vascular component, followed by a single session with an ablative Er:YAG laser. After 4 weeks, healing with good cosmetic results was observed (Figure 2). At 6-month follow-up, there was no recurrence of the lesions.

Kimura disease, often considered the closest differential diagnosis for ALHE, is a rare lymphoproliferative fibroinflammatory condition. Patients present with subcutaneous nodules on the head and neck, often associated with lymphadenopathy. Elevated serum IgE levels and peripheral blood eosinophilia are common.[1] Another consideration in the differential diagnosis is cutaneous bacillary angiomatosis caused by *Bartonella* species,

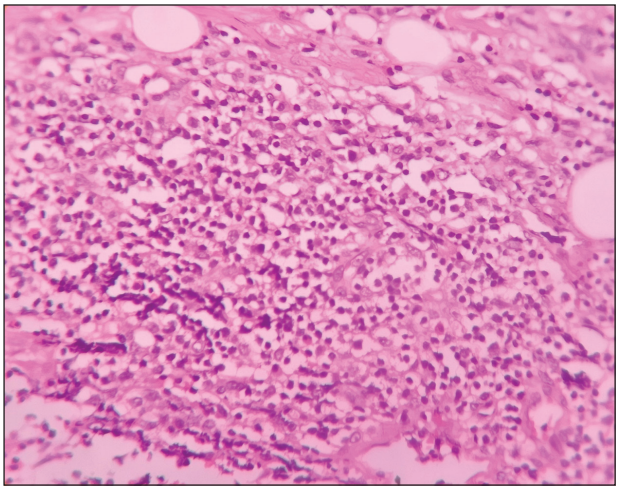

FIGURE 1. Histopathologic examination showed vascular proliferation accompanied by variable lymphocytic and eosinophilic infiltrate (H&E, original magnification ×100).

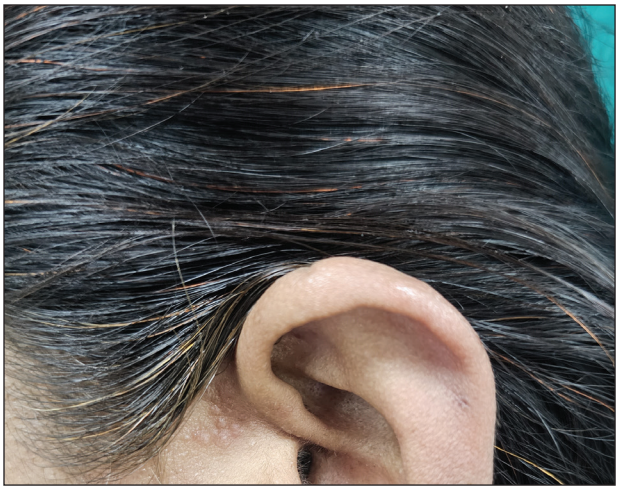

FIGURE 2. The patient experienced excellent healing with good cosmetic results 6 months after treatment with the combined long-pulse Nd:YAG and ablative Er:YAG lasers.

a vascular proliferative condition that mostly affects individuals with HIV, transplant recipients, and those taking immunosuppressive medications.[4] Pyogenic granuloma, also known as lobular capillary haemangioma, is another benign vascular proliferation that resembles ALHE. Clinically, it manifests as a solitary, painless, flesh-colored to erythematous papulonodule; however, multiple grouped lesions also can occur. The lesions often are associated with bleeding and erosions.[5] Epithelioid hemangioendothelioma is a rare vascular tumor most frequently manifesting in the liver, lungs, or bones, and very rarely is limited to skin. Cutaneous epithelioid hemangioendothelioma mimics ALHE and may manifest as a solitary erythematous mass, multiple dome-shaped masses, or dermal nodules.[6]

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