Letters to the Editor

Idiopathic Eruptive Macular Pigmentation in an Indian Male

Sir,

We report a 24-year-old man who presented with asymptomatic dark brown lesions over the face and trunk of 20 years duration. They appeared spontaneously without any preceding erythema or topical/systemic therapy. The lesions started insidiously and gradually progressed over a period of 3 years followed by a quiescent phase of around 16 years and aggravation 1 year before presenting to us. The general physical and systemic examination was unremarkable. Cutaneous examination revealed multiple brownish-gray to dark, discrete, round-to-oval, barely elevated plaques of size 0.5 to 2 cm [Figure 1a and b]. Most of the lesions had a velvety texture. Palms and soles were spared. He also had mild acanthosis nigricans of bilateral axillae [Figure 1c]. The mucosae, hair, and nails were normal. Darier’s sign was negative. Hematological and biochemical investigations including fasting blood sugar, glycosylated hemoglobin, and fasting insulin levels were normal. Skin biopsy showed irregular acanthosis, papillomatosis [Figure 2], keratin horn formation, and...
Letters to the Editor

Figure 1: (a) Multiple hyperpigmented plaques on the trunk. (b) Close up picture showing velvety hyper pigmented plaque. (c) Acanthosis nigricans in axilla

Figure 2: Skin biopsy H&E stain showing irregular acanthosis, papillomatosis, keratin horn formation, and basal layer hyperpigmentation

Figure 3: Skin biopsy H&E stain showing prominent basal layer hyperpigmentation

basal layer hyperpigmentation [Figure 3]. The upper dermis showed sparse superficial lymphohistiocytic infiltrate. Few melanophages were seen in the papillary dermis. The mast cell number was normal on hematoxylin and eosin stain. A diagnosis of idiopathic eruptive macular pigmentation (IEMP) was made based on characteristic clinical and histopathological features.

The patient was started on topical tretinoin 0.05% application once daily for 2 months without much improvement, following which it was discontinued.

IEMP is a rare disorder of pigmentation of unknown etiology. It was first described by Degos et al.\(^1\) in 1978, and since then, less than 50 cases have been reported. Joshi et al.\(^2\) have reported the largest series of 48 cases. IEMP is self-resolving and has been reported to disappear spontaneously in months to years. An unusual case IEMP lasting for 21 years in a 24-year-old woman was characterized by several periods of spontaneous resolution followed by recurrences.\(^3\)

The diagnostic criteria for IEMP were given by Sanz de Galdeano et al.\(^4\) in 1996 which includes (a) Eruption of brownish, nonconfluent, asymptomatic macules involving the trunk, neck, and proximal extremities in children and adolescents; (b) absence of preceding inflammatory lesions; (c) no previous drug exposure; (d) basal layer hyperpigmentation of the epidermis and prominent dermal melanophages without visible basal layer damage or lichenoid inflammatory infiltrate; (e) normal mast cell count.\(^4\) Our patient fulfilled all these criteria.

Recently, lesions occurring in a Christmas tree pattern\(^5\) and limited to flexures\(^6\) have been described. The differential diagnosis include lichen planus pigmentosus (LPP), erythema dyschromicum perstans (EDP), fixed drug eruption, and mastocytosis. However, none of these have velvety lesions. In IEMP, a preceding cause is absent and Darier’s sign is negative. The disease occurs primarily during childhood and adolescence usually without a history of erythema or drug medication unlike FDE. LPP is characterized by hyperpigmented, dark-brown macules in sun-exposed areas and flexural
There are no conflicts of interest.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

---

**Table 1: Cases published till date with histological emphasis on pigmented papillomatosis**

| Number of patients | Age of onset (years) | Site                      | Size                  | Duration (years) | Basal cell melanization | Pigmented Papillomatosis | Year of publication |
|--------------------|----------------------|---------------------------|-----------------------|------------------|-------------------------|-------------------------|---------------------|
| 5                  | 2-16                 | Trunk, neck, arms, legs   | 3-25 mm               | 1-4              | +                       | + (mixed for different cases) | 1996 (4)            |
| 1                  | 24                   | Trunk, arms               | 21                    | +                | -                       | 2003 (3)                |
| 1                  | 31                   | Trunk, thigh, forearm     | 2-7 cm                | 2                | +                       | -                       | 2005 (8)            |
| 9                  | 6-14                 | Face, trunk, arms, legs   | Up to 3 cm            | 2                | -                       | +                       | 2007 (9)            |
| 1                  | 23                   | Axilla, cubital fossa, inguinal area | 3 | + | - | 2008 (6) |
| 1                  | 21                   | Face, trunk, arms, legs   | 0.5-2 cm              | 2                | +                       | +                       | 2010 (7)            |
| 2                  | 7-13                 | Face, trunk, arms, legs   | 5-15 mm               | 4-8 months       | +                       | +                       | 2010 (10)           |
| 1                  | 10                   | Trunk, arms, legs         | 1-3 cm                | 3 months         | +                       | +                       | 2011 (11)           |
| 1                  | 22                   | Trunk                     | 1                     | +                | -                       | 2013 (5)                |
| 1                  | 11                   | Face, trunk, arms, legs   | 0.5-3 cm              | 3 months         | +                       | +                       | 2014 (12)           |
| 1                  | 6                    | Distal extremities        |                       |                  | +                       | +                       | 2014 (13)           |
| 1                  | 8                    | Face, trunk, arms, legs   | 2-15 mm               | 3 months         | +                       | +                       | 2015 (14)           |
| 1                  | 5                    | Neck, trunk, legs         | 10 months             | +                | +                       | 2016 (15)              |
| 1                  | 7                    | Face, trunk, arms, legs   | 7                     | +                | +                       | 2016 (16)              |
| 1                  | 19                   | Face, trunk               | 6 months              | +                | -                       | 2016 (17)              |
| 1                  | 20                   | Face, trunk, arms, legs   | 0.5-2 cm              | 1.5              | +                       | +                       | 2016 (18)           |

**References**

1. Degos R, Civatte J, Belaich S. La pigmentation maculeuse eruptive idiopathique. Ann Dermatol Venereol 1978;105:177-82.
2. Joshi RS, Rohatgi S. Idiopathic eruptive macular pigmentation: A critical review of published literature and suggestions for revision of criteria for diagnosis. Indian J Dermatol Venereol Leprol 2015;81:576-80.
3. Mehta S, Aasi S, Cole R, Chu P, Weinberg JM. Idiopathic eruptive macular pigmentation associated with pregnancy and Hashimoto thyroiditis. J Am Acad Dermatol 2005;52:919-21.
4. Sanz de Galdeano C, Léauté‑Labrèze C, Bioulac‑Sage P, Nikolic M, Taieb A. Idiopathic eruptive macular pigmentation: Report of five patients. Pediatr Dermatol 1996;13:274-7.
5. Oiso N, Kawada A. Idiopathic eruptive macular pigmentation following a Christmas tree pattern. J Dermatol 2013;40:934-5.
6. Kim EH, Lee ES, Kim YC, Kang HY. A case of idiopathic eruptive macular pigmentation limited to flexural areas. Ann Dermatol 2008;20:98-101.
7. Joshi RS, Palwade PK. Idiopathic eruptive macular pigmentation or acanthosis nigricans? Indian J Dermatol Venereol Leprol 2010;76:591.
8. Milobratovic D, Djordjevic S, Vukicevic J, Bogdanovic Z. Idiopathic eruptive macular pigmentation associated with pregnancy and Hashimoto thyroiditis. J Am Acad Dermatol 2005;52:919-21.
9. Joshi R. Idiopathic eruptive macular pigmentation with papillomatosis: Report of nine cases. Indian J Dermatol Venereol Leprol 2007;73:402-5.

---

**letters to the editor**

Chairman, Indian Dermatology Online Journal | Volume 8 | Issue 5 | September-October 2017

Indian Dermatology Online Journal | Volume 8 | Issue 5 | September-October 2017

---

There is acanthosis, basal cell hyperpigmentation, and dermal melanophages. The histopathological finding “pigmented papillomatosis,” which is a characteristic feature reported in a series of nine cases from India was present in our case too.[4-18] Emphasis has been laid on the histological presence of pigmented papillomatosis to be a diagnostic criteria for IEMP [Table 1].[4-18]

This case is reported for its rarity with an objective to increase its awareness among dermatologists and pathologists. Although it has been called as eruptive acanthosis nigricans in view of clinical and histological similarity, there was no metabolic derangement in our patient. He had associated acanthosis nigricans of axillae which may suggest a possible relationship between these disorders. The clinical course of our patient was different as he never had spontaneous resolution but his disease stopped progressing followed by a sudden aggravation 16 years later.

---

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.
A 32-year-old female presented to us with complaint of loss of sweating on most of the left side of the trunk, bilateral upper limbs, lower limbs, right side of face, palms, and soles associated with compensatory hyperhidrosis on right side of the abdomen [Figure 1]. There was no history of trauma, diabetes mellitus, collagen vascular disease, or previous history of fever, dyspnoea, palpitation, giddiness, hypotension, pain abdomen, or diarrhoea. There was no history of headache, dyspnoea, palpitation, giddiness, hypotension, pain abdomen, or diarrhoea. There was no history of any trauma to the body along with generalized burning sensation on sun exposure. There was no history of headache, dyspnoea, palpitation, giddiness, hypotension, pain abdomen, or diarrhoea.

On physical examination, the patient was alert, conscious, and oriented to person, place, and time. Her blood pressure and pulse rate were normal in the supine as well sitting position. Rest of the cutaneous and systemic examination was normal. On nervous system examination, deep tendon reflexes were absent. Blood pressure was normal in supine as well sitting position. Rest of the cutaneous and systemic examination was normal.

Moreover, there was hypoplasia of bilateral 4th and 5th dermatomal distribution (dermatomal distribution T8–T12) and left side of face. Anhidrosis may be accompanied by other alterations of the autonomic nervous system like decreased sweating, orthostatic hypotension, absence of vasomotor reactions, reduced sexual function, and altered bowel and bladder function. A rare finding, the absence of miosis, may occur inHarlequin syndrome.

Depression of deep tendon reflexes is due to dorsal root ganglionic degeneration and spinal interneuron loss. The number of postganglionic sympathetic fibres projecting to the iris and sweat glands may be decreased in the anhidrotic skin. The number of eccrine sweat glands may be decreased in the anhidrotic skin. Anhidrosis may be accompanied by other alterations of the autonomic nervous system like decreased sweating, orthostatic hypotension, absence of vasomotor reactions, reduced sexual function, and altered bowel and bladder function. A rare finding, the absence of miosis, may occur in Harlequin syndrome.

Our patient presented with all typical features of Ross syndrome along with an additional finding of toe hypoplasia. Our patient presented with all typical features of Ross syndrome along with an additional finding of toe hypoplasia. Our patient presented with all typical features of Ross syndrome along with an additional finding of toe hypoplasia.

Our patient presented with all typical features of Ross syndrome along with an additional finding of toe hypoplasia. Our patient presented with all typical features of Ross syndrome along with an additional finding of toe hypoplasia. Our patient presented with all typical features of Ross syndrome along with an additional finding of toe hypoplasia. Our patient presented with all typical features of Ross syndrome along with an additional finding of toe hypoplasia.