

due to repetitive use of the work gloves on the basis of the patient's history, patch tests, and use tests.

Thiurams are accelerants that are commonly used to manufacture natural rubber latex products. These mixes are present in natural or synthetic rubber products making up materials that are used either at work or at home⁴. Many tire workers are sensitized to black rubber mix. Concerning nonoccupational exposure, it has been shown that black rubber footwear and the rubber tips of walking sticks can also cause contact dermatitis⁵. Positive reaction to *p*-tertbutylphenol formaldehyde resin is related to contact with waterproof glue, bonded leather, and construction materials, whereas that to *p*-phenylenediamine is related to contact with permanent or semipermanent hair dyes, dyed textiles, and cosmetics; however, these are less relevant compared with our case. In conclusion, this report suggests that patients with HHE should be comprehensively evaluated through history taking and correctly treated by avoiding the suspicious material.

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Sacroccocygeal Nodule in a Young Male Patient

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Dear Editor:

A 22-year-old male patient was referred to our dermatologic clinic, from the department of orthopedic surgery of our hospital, for the evaluation of a cutaneous mass-like lesion on the sacroccocygeal area. The patient noticed the skin lesion 3 months previously, without any subjective

symptoms. Physical examination revealed a solitary skin-colored, slightly hard nodule with scales on the coccygeal area (Fig. 1A). Radiographic examination showed no definite abnormality on the pelvis. Skin biopsy was performed, and the findings showed mild hyperkeratosis and thickening of collagen bundle in the dermis (Fig. 1B, C).

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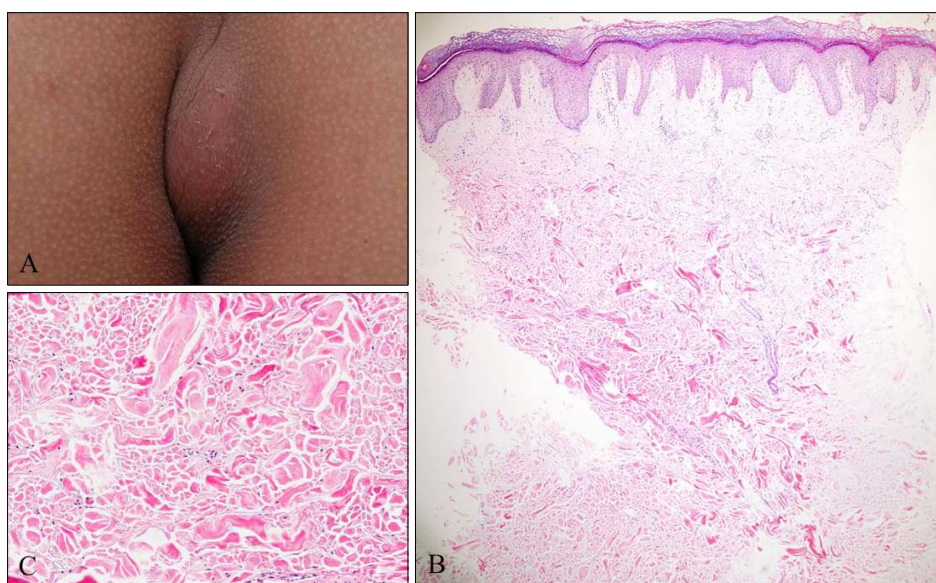


Fig. 1. (A) Solitary skin-colored nodule with scales is located in coccyx. (B) Hyperkeratosis and up-peridermal edema, and marked increased dermal thickness are observed at the lower magnification (H&E, $\times 10$). (C) Thickening of individual collagen bundles are noted at the higher magnification (H&E, $\times 100$).

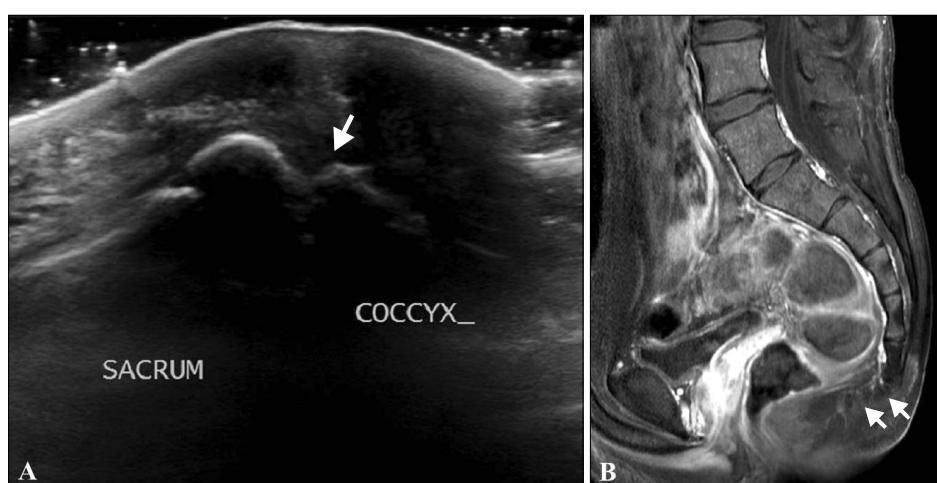


Fig. 2. (A) Abrupt angle of sacrococcygeal junction (arrow) under the nodular skin lesion was visualized through sonogram. (B) Anterior dislocation of the coccyx (arrows) was visualized through T1-weighted sagittal view of magnetic resonance imaging examination.

No cystic or sinus structures were observed. An abrupt angle of the sacrococcygeal junction under the nodular lesion was noted on sonographic examination (Fig. 2A). Magnetic resonance imaging also confirmed the angulated sacrococcygeal joint under the nodule (Fig. 2B). On the basis of the clinical, histopathological, and imaging findings, a diagnosis of “coccygeal pad” was concluded.

Coccygeal pad was introduced in 1985, and almost all cases have been reported from Japan with various terminologies such as tylosis-like eruption, isolated collagenoma, coccygeal nodule, and coccygeal pad¹⁻³. The typical clinical feature is an asymptomatic oval nodular mass at the coccyx. The nodular lesion arises from dermal thickening due to proliferation of collagen bundles². Almost all reported cases were in school-age children who use chairs with a hard wooden seat. Radiological findings show abrupt angulation at the sacrococcygeal level, i.e.,

anterior dislocation of the coccyx. Therefore, it was suggested that chronic mechanical pressure on and irritation of the coccyx in young patients may contribute to the development of reactive fibrosis in the dermis.

When encountering young patients with a sacrococcygeal nodule, various disorders such as epidermal cyst, pilonidal sinus, and sacrococcygeal teratoma should be differentiated. Sacrococcygeal teratomas are tumors characterized by skin discolorations or sacral masses⁴. The teratoma is composed of mature tissue, such as neural and/or glandular components, derived from any embryonic layer⁴. Pilonidal sinus usually presents with suppuration features such as abscess or chronic purulent discharge⁵. The histologic features include sinus tract formation with a squamous epithelium, with various degrees of inflammation and hair growth.

In conclusion, we report the case of a sacrococcygeal

nodule in a young man that was diagnosed as coccygeal pad on the basis of clinical, histological, and imaging tests. The nodular lesion seems to be related to chronic irritation in the coccygeal area.

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A Case of Sarcoidosis Presenting as Livedo

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Dear Editor:

A 57-year-old woman presented to our hospital in April 2012 with a chief complaint of a 2-month history of swelling and erythema of both lower extremities. Her medical history was significant for bilateral uveitis, which had been followed by physicians in Department of Ophthalmology, Tokyo Medical and Dental University. Her family history was unremarkable. Physical examination revealed inarticulate erythema with edema, subcutaneous nodules, and livedo of her lower extremities (Fig. 1A). Her laboratory values were within reference limits, except for serum lysozyme (17.2 $\mu\text{g/ml}$; reference, 4.2~11.5 $\mu\text{g/ml}$)

and angiotensin-converting enzyme (ACE, 32.8 IU/L; reference, 7.7~29.4 IU/L), which were slightly elevated. Plain film roentgenography and computed tomography of the chest revealed bilateral hilar lymphadenopathy (BHL) and nodules in the inferior lobe of the right lung.

A biopsy was obtained from the subcutaneous nodule within an area of the livedo on her left lower extremity. Histologically, the epidermis appeared normal. The middle and lower dermis, as well as the subcutaneous tissue, contained disseminated noncaseating epithelioid granulomas, surrounded by a mixed infiltrate of lymphocytes (Fig. 1B). Moreover, the center of many granulomas contained damaged blood vessels. The lumina of the blood vessels were narrowed and occluded with fibrin (Fig. 1C~E).

The patient's condition was diagnosed as sarcoidosis and livedo because of the presence of obliterative changes to the vessels and surrounding granulomas. Treatment with oral prednisolone (30 mg/day) resulted in prompt improvement in the patient's cutaneous lesions and BHL, as well as normalization of the serum levels of lysozyme and ACE.

Thus, the patient in our case report appears to have a rare cutaneous presentation of sarcoidosis, the so-called livedo-

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