Dermoscopic Features of Atrophoderma Vermiculatum; Differentiation from its Clinical Look Alike

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An 8-year-old male presented with asymptomatic, progressive, atrophic scarring over upper lip for the last 6 months. Patient denied any history of preceding inflammatory lesions. On examination, grouped, skin-colored, atrophic-pitted scars were seen over upper lip and adjoining area [Figure 1a]. Few atrophic scars and keratotic papules were present on bilateral cheeks and bilateral upper arm. Clinical diagnosis of atrophoderma vermiculatum (AV) was made.

Dermoscopy revealed bizarre, polymorphic scars of varying shapes (oval, linear, stellate shaped) and sizes in perifollicular location (corresponding to perifollicular fibrosis on histopathology). Diminished lesional hair density was noted [Figure 1b]. Few scars had a reddish-pink background (corresponding to resolving inflammation on histopathology). Histopathological examination from upper lip showed follicular hyperkeratosis, perifollicular fibrosis, and mild lymphocytic infiltrate in perifollicular and peri-appendageal areas [Figure 2]. A final diagnosis of AV was made.

AV, a clinical variant of keratosis pilaris atrophicans, typically presents in childhood with erythema and follicular papules which eventually progress to atrophic scarring termed "worm eaten or reticular or honeycomb" appearance. AV presents as symmetrical lesions over cheeks, forehead, and pre-auricular area which may rarely extend to upper lip and helices.[1] Contrary to the typical presentation, our patient had unilateral distribution with decreased hair density which is rare. Dermoscopy of AV was not described earlier. One close differential of AV is atrophia maculosa varioliformis

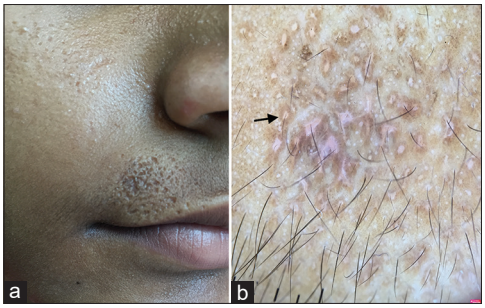

Figure 1: (a) Grouped atrophic and pitted scars in honeycomb pattern; and (b) dermoscopy (Dermlite DL4 3Gen noncontact, polarized mode at 10× magnification) Bizarre, polymorphic scars of varying shapes (oval, linear, stellate shaped) and sizes in perifollicular location (arrow)

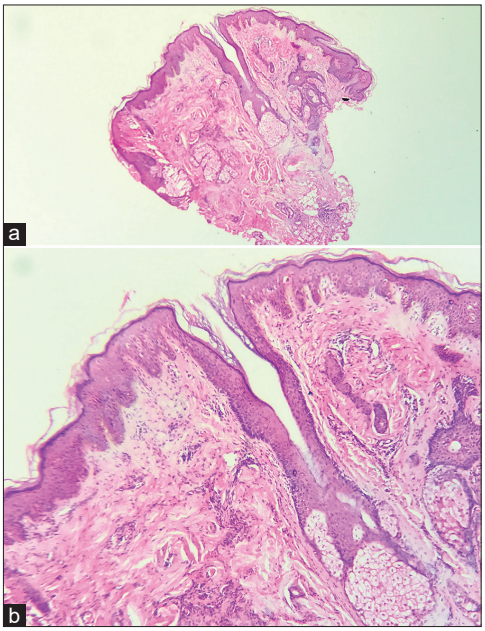

Figure 2: (a and b) Histopathologic examination shows follicular hyperkeratosis, perifollicular fibrosis, and mild lymphocytic infiltrate in perifollicular and peri-appendageal areas (H and E, 4×; 20×)

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How to cite this article: Chauhan P, Daroach M. Dermoscopic features of atrophoderma vermiculatum; Differentiation from its clinical look alike. Indian Dermatol Online J 2023;14:748-9.

Received: 30-Sep-2022. **Revised:** 15-Nov-2022. **Accepted:** 21-Nov-2022. **Published:** 10-Jul-2023.

Access this article online

Website: https://journals.lww.com/idoj

DOI: 10.4103/idoj.idoj_513_22

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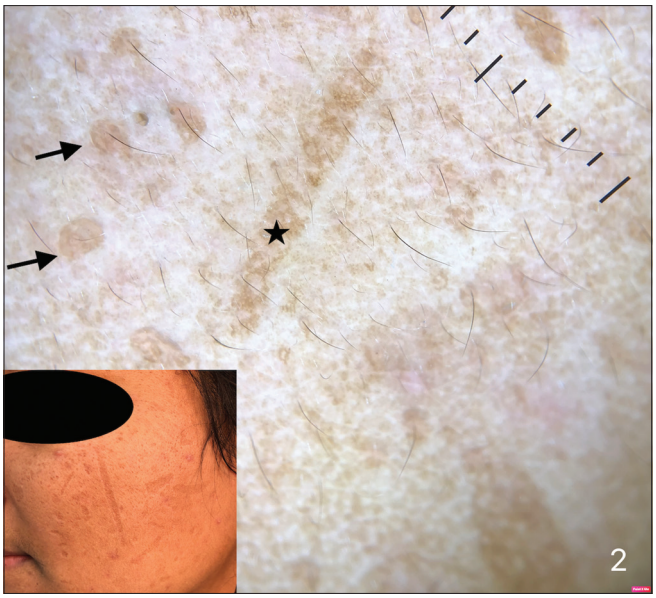

Figure 3: Dermoscopy (Dermlite DL4 3Gen noncontact, polarized mode at 10× magnification) of atrophia maculosa varioliformis cutis shows well-defined, linear, or round scars characterized by brownish pigment network and perilesional hypopigmentation distributed in both follicular (solid arrows) and nonfollicular areas (star) (inset shows clinical morphology)

cutis (AMVC), wherein no inflammatory lesions precede the scars. We further performed dermoscopy in a classic case of AMVC which showed well-defined, linear, or round scars characterized by brownish pigment network and perilesional hypopigmentation distributed in both follicular and non-follicular areas [Figure 3]. Another clinical differential that was considered was follicular atrophoderma, but it occurs over hands and feet and classically has syndromic associations.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

Reference

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