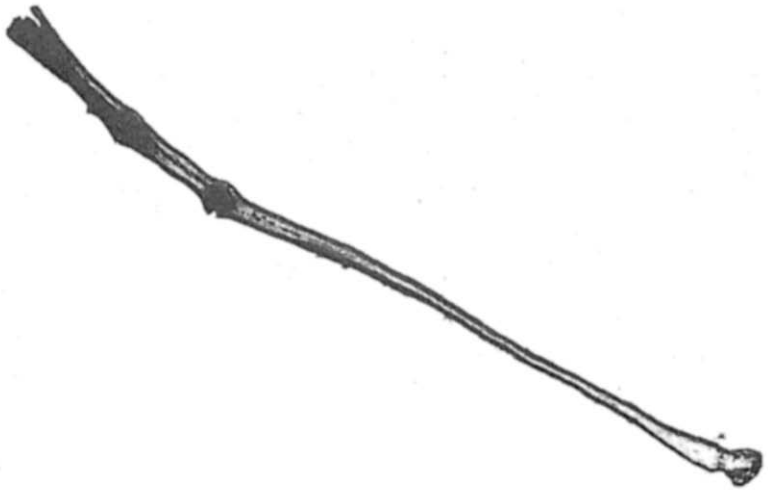

Fig. 2. "Exclamation point" hair removed with epilating forceps.

endocrine-autonomic disease, and (3) yearly recurrence of hair loss (after complete regrowth) in a definite season. Our patient fits into this group by virtue of the first and third criteria. The atopic type of alopecia areata has a 2:1 male/female ratio, a 10:1 adult/childhood onset ratio, progression to alopecia totalis in one third of patients (vs 5% in the common type of alopecia areata), and duration of more than 3 years in 83% of patients (vs 4.7% in the common type of alopecia areata).[4]

The common thread between alopecia areata and atopy remains obscure. Both disorders, however, have associated abnormalities in cell-mediated immunity. Many conflicting studies have found a variety of T cell aberrations both in patients with atopic disease and in patients with alopecia areata.[3, 5] The significance of these immunologic abnormalities in the pathogenesis of either disorder is unknown. The repeated temporal relationship between atopic flares and effluvium does, however, point toward a common precipitating factor in these problematic disorders. Our patients yearly progression in the extent of his hair loss may portend a poor ultimate outcome, as Ikeda's work indicates.[2]

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Treatment of xanthelasma with Solcoderm

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We report our experience in the treatment of xanthelasma with Solcoderm, a recently introduced complex of organic and inorganic acids with copper in solution. One hundred two lesions in 47 patients were treated during a 2-year period. In 55% of the cases the individual lesions measured 0.5 cm or less in diameter. In 45% of cases they either were confluent or measured more than 0.5 cm in diameter. A total of 68 lesions less than 0.5 cm and 34 lesions more than 0.5 cm in diameter were treated. Solcoderm was supplied by the manufacturer (Solco, Basel AG, Birsfelden, Switzerland) as a solution containing copper ions, 15 ppm; oxalic acid, 40 mg/ml; lactic acid, 3 mg/ml; nitrate, 410 mg/ml, and acetic acid, 40 mg/ml. Treatment was administered by a technique described in an earlier study.[1] Two weeks after treatment, punch biopsy specimens from selected patients were obtained from the site of the lesion for histologic evaluation.

Results. The results of treatment are summarized in Table I. Complete disappearance of the lesions with residual scarring was observed in 97% of lesions less than 0.5 cm in diameter (Fig. 1). In only two lesions in this

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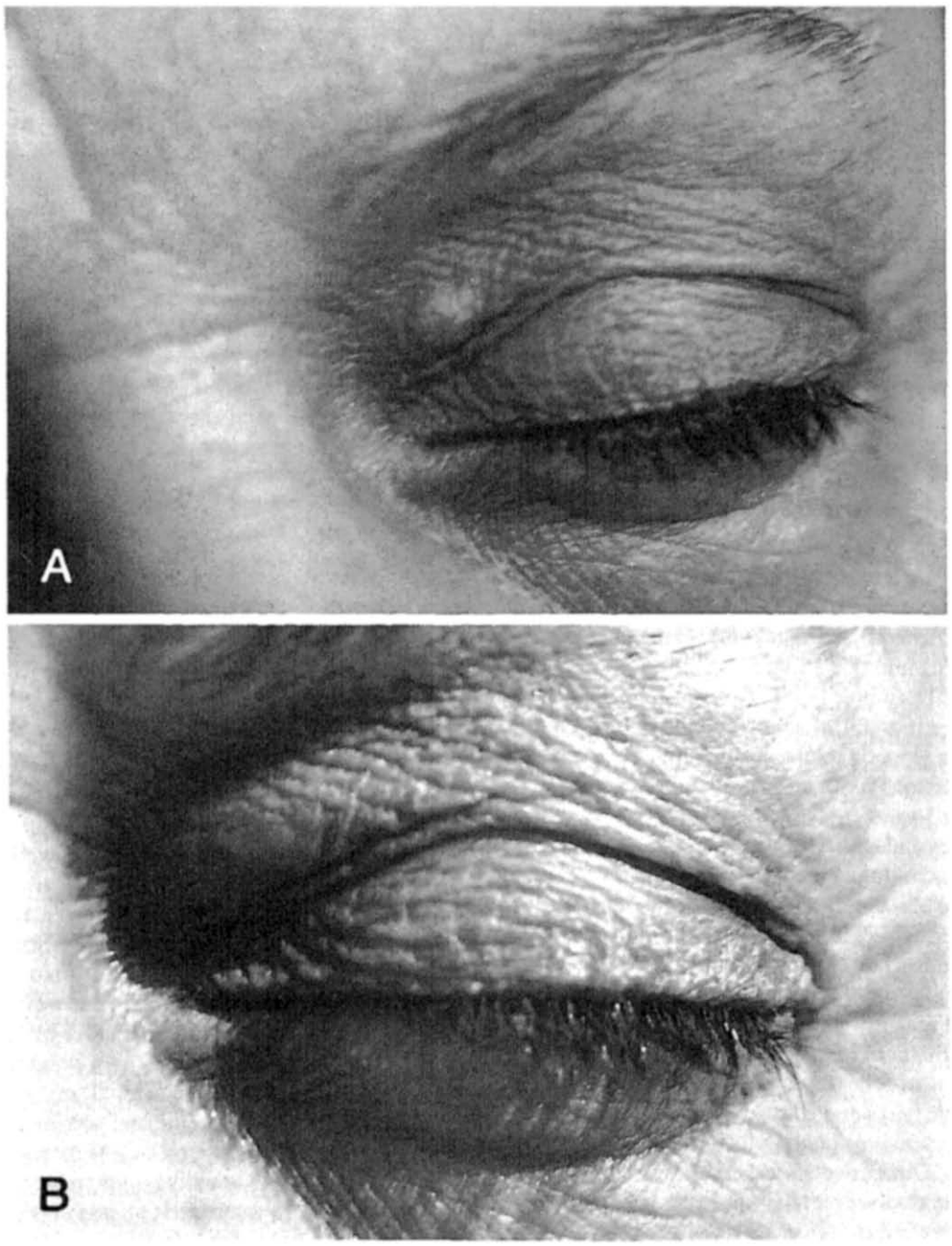

Fig. 1. A, Small xanthelasma 0.5 cm in diameter before treatment. **B,** Disappearance of lesion after 1 week of treatment with Solcoderm.

Table I. Comparative results of Solcoderm treatment for lesions greater than and smaller than 0.5 cm in 47 patients with xanthelasma

Size of lesion (cm)	No. of patients treated	No. of lesions	Effect of Solcoderm on lesion			
			Disappearance after wk 1 of Tx	Residual scar after wk 1 of Tx	Yellow ring formation	Total disappearance after subsequent Tx
<0.5	26	68	66	2	0	2
>0.5	21	34	4	12	18	30

Tx, Treatment.

group a small residual scar resulted. These scars subsequently disappeared after repeated treatment. Of the 34 lesions greater than 0.5 cm in diameter, 4 disappeared completely after 1 week of treatment and in 12 a slightly raised scar developed, which disappeared after an additional 1 to 2 weeks of treatment. Treatment in 18 cases resulted in the formation of a slightly raised, serpiginous, yellow ring that also disappeared after an additional week of treatment. Histologic examination of the biopsy specimens after treatment revealed total disappearance of the foam cells from the dermis and replacement by dense scar tissue. No recurrences were observed in any patient after successful treatment during a 2-year follow-up period.

Discussion. Solcoderm has been recently introduced for the treatment of cutaneous neoplasia.[2] It rapidly fixes tissue with preservation of fine cellular structure, a process that has been likened to tissue mummification.[3] The compound has been found to be particularly useful in situations in which the location of the lesion would make surgery technically difficult or undesirable.[4] Previous studies on the effects of treatment with Solcoderm in patients with basal cell carcinoma have shown that the depth of penetration is directly affected by the depth of the lesion and the presence or absence of a fibrous stroma in the lesion.[1] The superficial location of xanthelasma and the nearly complete absence of fibrosis renders these lesions particularly suitable for treatment with Solcoderm. The results of our study indicate that treatment of xanthelasma with Solcoderm is a viable alternative to other modalities.

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'Butterfly' sign

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The "butterfly" sign is defined by Reynolds[1] as an area of decreased pigmentation of an area on the back that is unreachable by the patient and that has a butterfly shape.

As shown by this similar picture of a patient with vagabond's leukoderma (Fig. 1) without jaundice or a hepatobiliary disorder and with no antimitochondrial antibodies, this sign reflects severe and persistent pruritus rather than a precise cause.[2]

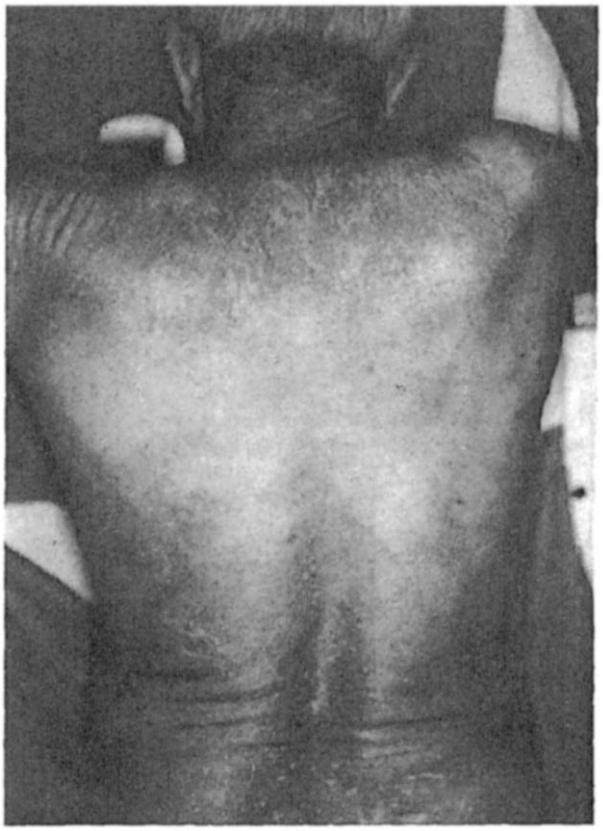

Fig. 1. Butterfly-shaped area of depigmentation on back of patient with vagabond's leukoderma.

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Multiple keratoacanthoma in discoid lupus erythematosus

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Multiple and generalized forms of keratoacanthoma are two rare variants of keratoacanthoma that can arise

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