Guttate Hypomelanosis and Milia

May 01, 2004
By David L. Kaplan, MD [1]

For several months, a 49-year-old woman has had asymptomatic loss of pigment on her shins. She has no history of injury to the area. What is your clinical impression?

Case 1:
For several months, a 49-year-old woman has had asymptomatic loss of pigment on her shins. She has no history of injury to the area.


Case 1: Guttate hypomelanosis, D, is attributable to long-term sun exposure that results in hypopigmentation from loss of melanocytes. It is typically seen on the shins and forearms and is confined to sun-exposed surfaces. This distribution and appearance distinguish it from vitiligo. Lichen planus can be associated with loss of pigment but is also associated with epidermal changes that are not seen here. Lichen planus generally presents as flat-topped purple polygonal papules sometimes accompanied by sparse scale in the skin lines (Wickham striae). The patient has no history of trauma; moreover, the distribution and appearance do not suggest that the lesions were traumatically induced. Tinea versicolor is associated with scaling, which is absent here; it is typically distributed on the trunk. Sunscreen is the first-line treatment for guttate hypomelanosis. Some success has been reported anecdotally with tretinoin and alpha hydroxyl acids.

Case 2:
A 45-year-old woman complains that she has had asymptomatic white "bumps" on her cheeks for the past few months. What does this eruption look like to you? A. Acne. B. Keratosis pilaris. C. Milia. D. Rosacea.
E. Sebaceous hyperplasia.
Which of the following treatments would you consider? 
A. Adapalene.
B. Tretinoin.
C. Tazarotene.
D. Azelaic acid.

e. Salicylic acid.

**Case 2:**
The papules are **milia,** small occlusion cysts that can erupt at any age. Acne usually presents with a combination of open and closed comedones, as well as papules. Keratosis pilaris generally occurs in infants and children, not adults. Rosacea typically presents with erythema and small inflammatory papules and pustules. Sebaceous hyperplasia manifests with yellowish papules that have a central punctum. Adapalene, tretinoin, tazarotene, azelaic acid, and salicylic acid have all been used to treat milia; however, the lesions may be slow to respond. Milia can also be extracted manually or lightly electrodessicated with a cautery unit.

**Case 3:**
A 68-year-old man with long-standing "arthritis" presents with an eruption on the thumb that had developed over the course of 2 years.
Which condition do you suspect is responsible for the patient's lesion? 
A. Rheumatoid arthritis.
B. Psoriatic arthritis.
C. Gout.
D. Osteoarthritis.
E. Calcinosis cutis.
**Bonus question:** True or false? Ninety-five percent of cases of this disorder occur in men.

**Case 3:**
Tophi—nodular collections of sodium urate crystals that can rupture spontaneously—are characteristic of **gout,** C. The differential includes calcinosis cutis, a condition sometimes associated with connective tissue diseases and marked by deposits of calcium salts in the skin. These can occur around the fingers and erupt spontaneously. Examination of the discharged material helps distinguish gout from calcinosis cutis. Spontaneous extrusion is not associated with rheumatoid arthritis, psoriatic arthritis, or osteoarthritis. **Answer to bonus question:** True; 95% of cases of
Guttate Hypomelanosis and Milia
Published on
Pediatrics
ConsultantLive (https://www.pediatricsconsultantlive.com)

Case 4:
Hyperpigmentation developed on the face of a 35-year-old woman during her last pregnancy, but it did not resolve following childbirth.
You advise the patient to avoid excessive sun exposure and to use a sunscreen with an SPF of at least 15.
Which of the following ingredients would you tell her to look for on the label of a sunscreen product?
A. Homosalate.
B. Zinc oxide.
C. Methoxycinnamate.
D. Oxybenzone.
E. Butyl methoxydibenzoylmethane.
F. Octocrylene.
G. Titanium dioxide.

Bonus question: Which medication(s) can aggravate this condition?
Case 4:
The patient has melasma, hyperpigmented patches that occur on the face of some pregnant women. Melasma is aggravated by UV-A light. Zinc oxide, butyl methoxydibenzoylmethane, and titanium dioxide (B, E, and G) are efficient blockers of UV-A; the others are much weaker. Answer to bonus question: Oral contraceptives can aggravate melasma in some patients.

Source URL:

Links: