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A Case of Reticulate Acropigmentation of Kitamura Treated with 532-nm Q-Switched Nd:YAG Laser: 10 Years of Follow-Up Observation

Jae Hyung Lee, Jong Hee Lee, Joo Heung Lee

Department of Dermatology, Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Korea

Dear Editor:

Reticulate acropigmentation of Kitamura (RAPK) is an uncommon pigmentary disorder that was first reported in Japan¹. Since then, similar cases have been described worldwide; nevertheless, most were still in Japanese patients². RAPK shows reticulate hyperpigmentation of the dorsum of the acral areas without hypopigmented macules. Despite the report of using 20% azelaic acid to treat RAPK, there has been no certain treatment guaranteeing a clinical effect for more than half a century³. Herein, we present a patient with RAPK who was successfully treated with 532-nm Q-switched Nd:YAG laser (532-nm QSND; MedLite IV Nd:YAG laser; HOYA ConBio, Fremont, CA, USA).

A 29-year-old Korean woman visited our dermatologic clinic for childhood-onset acral hyperpigmentation in March 2002. Reticulate acral hyperpigmentation was recognized but no interspersed hypopigmentation was

detected. She had no family history of pigmentary disorder. She neither had taken medication known to induce hyperpigmentation nor had a history of contact to any chemical agent that can cause pigmentary changes. She underwent skin biopsies for the hyperpigmented confluent patch on the dorsum of the hand and discrete hyperpigmented macule on the dorsum of the foot. Histologically, lentiginous melanocytic hyperplasia and some dermal melanophages were observed with mild epidermal atrophy (Fig. 1). On the basis of the findings, we made a diagnosis of RAPK. Considering the histologic findings of superficially situated melanocytic hyperplasia, we used 532-nm QSND. We tested the laser to evaluate its efficacy and safety. A small area of the left arm was selected as the test area. Topical anesthetic agent was applied on the area before treatment. Treatment with parameters of 4-mm spot size, 2 J/cm² was applied. Some pain was present during treatment but it was tolerable, and significant clinical

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Corresponding author: Joo Heung Lee, Department of Dermatology, Samsung Medical Center, Sungkyunkwan University School of Medicine, 81 Irwon-ro, Gangnam-gu, Seoul 135-710, Korea. Tel: 82-2-3410-3542, Fax: 82-2-3410-3869, E-mail: jooheung.lee@samsung.com

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Fig. 1. (A) Lentiginous melanocytic hyperplasia and dermal melanophages with some degree of epidermal atrophy (H&E, $\times 100$). (B) Lentiginous hyperplasia of the basal melanocytes (Fontana Masson, $\times 100$).

Fig. 2. (A) Reticulated brownish patches on the dorsum of both hands before treatment. (B) Significant improvement of hyperpigmentation after seven sessions of treatment. (C) Clinical improvement was maintained after 4 years without treatment. (D) Significant clinical improvement with a clear margin distinguishing the treated from the untreated area.

improvement was observed in the area without any complication. We gradually expanded the treatment area. During the sessions, mild blisters developed after treatment with 2.7 J/cm² or higher; however, they disappeared without leaving hyper- or hypopigmentation. A total of seven sessions of laser treatment, with energy between 2.0 and 2.7 J/cm², were successfully made from March 2002 to November 2007 (Fig. 2), and the interval between treatments was several months to 2 years. Thereafter, she was lost to follow-up for 4 years because of personal reasons. In March 2012, she visited our clinic for treatment of the remaining lesions. There was neither a recurrence of RAPK nor treatment-related adverse effects on the previously treated area. We treated the residual lesions with same parameters as previously used, and the clinical effect was also good.

Recently, Fahad et al.⁴ introduced the use of 755-nm Q-switched alexandrite laser as an effective modality to treat RAPK. In our case, the successful depigmentation with

532-nm QSND was made without a significant adverse reaction. We also observed the maintenance of clinical improvement for 10 years without any repigmentation on the treated area. Thus, 532-nm QSND may play a central role in the treatment of RAPK. As this is a single case of clinical experience, a follow-up study will be needed.

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A Case of Psoriasis Exacerbated by Radioactive Iodine Therapy

Yeon Soo Kang, Tae Yoon Kim

Department of Dermatology, Seoul St. Mary's Hospital, College of Medicine, The Catholic University of Korea, Seoul, Korea

Dear Editor:

Psoriasis is a chronic inflammatory skin disease that is characterized by erythematous, sharply demarcated papules and plaques covered by scales. Although the exact causes of psoriasis still remains obscure, it is known that genetic,

immunological, and environmental factors contribute to its etiopathogenesis. Several factors such as trauma, stress, infections, and medications may exacerbate psoriasis. The most common medications known to trigger or worsen existing psoriasis include lithium, gold salts, beta blockers,

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Corresponding author: Tae Yoon Kim, Department of Dermatology, Seoul St. Mary's Hospital, College of Medicine, The Catholic University of Korea, 222 Banpo-daero, Seocho-gu, Seoul 137-701, Korea. Tel: 82-2-2258-1380, Fax: 82-2-599-9950, E-mail: tykimder@catholic.ac.kr

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