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seasonal allergies, and she denied a history of acne, trauma, or similar lesions in family members. Physical examination showed flesh-colored, 2–4 mm diameter nonfollicular papules scattered diffusely on her shoulders, upper back, and midback (Figs. 1A, B). No surrounding erythema, pustules, plaques, or scales were seen. Eruptive collagenomas, acne scars, and anetoderma were the initial differential diagnoses. A 4-mm punch biopsy was performed, and histopathologic evaluation revealed an essentially normal epidermis. Focally in the mid and reticular dermis, the collagen bundles were miniaturized, appearing both shorter and thinner than adjacent fibers and arranged in a more compact fashion. A Verhoeff-Van Geison stain showed fragmented elastic fibers amidst the miniaturized collagen (Figs. 2A, B). Colloidal iron stain was negative for the presence of

mucin. Screening radiographs of hands and knees were performed and yielded no evidence of osteopoikilosis, sclerosis, or striated epiphyses, all findings would suggest an association with Buschke–Ollendorff syndrome. Complete blood count and chemistry panels were normal, as well as liver enzymes, antinuclear antibody and antiphospholipid antibodies. The patient was prescribed tretinoin 0.04% microgel for daily use over the affected areas. She has had no response to treatment and no progression of disease to date.

Our case is histologically and clinically most consistent with the diagnosis of PE with a unique feature of collagen miniaturization that has never before been reported. The diagnosis of PE can be challenging because of the heterogeneous group of elastic tissue disorders and connective tissue nevi. Additionally, although PE can be

A Pruritic Hypopigmented Cutaneous Eruption: Atypical Presentation of Papular Elastorrhexis

To the Editor:

Papular elastorrhexis (PE) is a rare disorder of elastic tissue that is infrequently reported in the literature. We present a case of a 29-year old Asian woman who presented with a 2-month history of an eruption of asymptomatic flesh-colored papules on her posterior neck and upper back. Her medical history included eczema and

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FIGURE 1. A, Photograph of hypopigmented papules distributed across the upper back. B, Inset of a close-up view of papules.

FIGURE 2. A, A $\times 4$ view (hematoxylin and eosin) of the skin biopsy showing localized collagen miniaturization and loss of elastic fibers. B, A high-power view ($\times 40$, Verhoeff-Van Geison stain) showing transition point between normal collagen and elastic fibers peripherally and closely spaced miniaturized collagen fibers with elastorrhexis.

observed secondary to inflammatory acne scarring,¹ our patient denied a history of acne and had no evidence of acne on examination. Knowledge of the existence of this entity is relevant to avoid unnecessary workups and counseling for systemic disease and genetic disorders, which are not associated with PE. Treatment is lacking regarding this condition, and currently intralesional kenalog and tretinoin have showed little efficacy.² Our patient declined the offer to pursue laser therapy with the ablative CO₂ fractional laser; however, this may be an option for future studies because of its favorable record of restoring collagen and elastic tissue architecture when treating hypertrophic scars.³ The diagnosis of PE should initiate counseling regarding the lack of treatment response to topical agents and the non-self limiting nature of the disease.

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