

**Table I.** Results of the telephone survey

Question	Result
What treatment plan was recommended for you by your dermatologist?	Included OTC medication in their treatment plan: 29%
	Included OTC treatment after it was explicitly asked: 36%
	Able to recall the name "benzoyl peroxide": 30%
Have you picked up your prescriptions?	Picked up their prescriptions: 93%
	Had trouble filling their prescription because of insurance problems: 6%
	Did not attempt to pick up their prescription: 1%
Have you picked up your OTC medications?	Did not purchase any OTC medication: 36%
	Did pick up/have an OTC medication: 64%
If applicable, what OTC products are you using or did you pick up after your dermatology appointment?	Contained benzoyl peroxide: 32%
	Contained salicylic acid: 15%
	Contained no active ingredient: 17%

OTC, Over-the-counter.

people who knew an OTC medication was recommended, most had difficulties remembering the name of the product that they were supposed to purchase. Furthermore, of those who remembered BP by name, many were unable to find the correct product and instead had purchased an item with the wrong ingredient or no active ingredient. These data indicate that patients need more guidance in their OTC acne treatment selection.

Limitations of this study are the inclusion of English-speakers only and the use of a nonvalidated telephone survey.

This study shows that patient adherence to dermatologist-recommended OTC BP for the treatment of acne is poor. Better education, in-office dispensing of BP, or fixed-dose combination prescription products are possible solutions.

Annie H. Huyler, BA,<sup>a</sup> and Andrea L. Zaenglein, MD<sup>a,b,c</sup>

Penn State College of Medicine,<sup>a</sup> Departments of Dermatology<sup>b</sup> and Pediatrics,<sup>c</sup> Penn State/Hershey Medical Center, Hershey, Pennsylvania

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Correspondence to: Andrea L. Zaenglein, MD, Department of Dermatology, HU14, Penn State/Hershey Medical Center, Hershey, PA 17033.

E-mail: [azaenglein@bmc.psu.edu](mailto:azaenglein@bmc.psu.edu)

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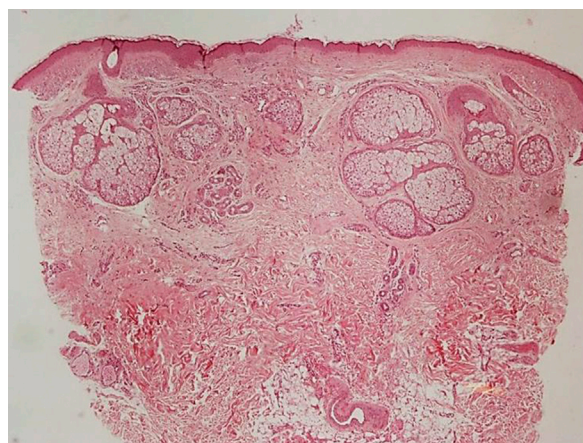
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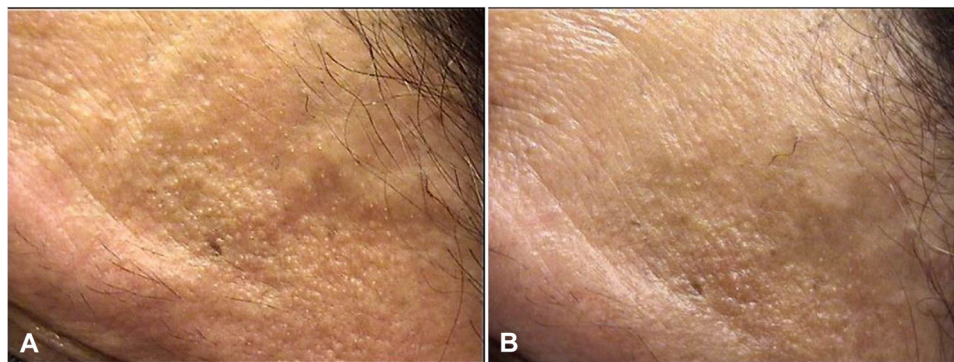
## Yellow facial papules associated with frontal fibrosing alopecia: A distinct histologic pattern and response to isotretinoin



*To the Editor:* Frontal fibrosing alopecia (FFA), described in 1994 by Kossard,<sup>1</sup> represents an increasingly recognized disease characterized by symmetrical and progressive frontotemporoparietal hairline recession.<sup>2</sup> Its etiology remains elusive, although a gene–environment interaction is probably



**Fig 1.** Histologic findings of a yellow facial papule. Hyper-trophic sebaceous glands in the papillary dermis not associated with vellus hair follicles or inflammatory infiltrate. (Hematoxylin–eosin stain; original magnification:  $\times 20$ .)



**Fig 2.** Frontal fibrosing alopecia with yellow facial papules on the temporal area. **A**, Initial clinical presentation characterized by altered texture with soft skin consistency. **B**, Visible reduction of the yellow facial papules 4 months after the treatment with oral isotretinoin 10 mg, every other day.

implicated.<sup>3</sup> Additional clinical features have been included in the definition of FFA with histopathologic confirmation, namely eyebrow loss, occipital and body hair involvement, glabellar red dots,<sup>4</sup> visible frontal veins, and facial papules.<sup>2</sup> The latter, described by Donati et al,<sup>5</sup> were associated with a lichenoid inflammation involving vellus hair follicles and perifollicular fibrosis. Recently, a series of 12 cases reviewing FFA facial lesions<sup>6</sup> reported that these apparently noninflammatory papules were depicted in 11 of 12 patients (91.7%) and displayed the aforementioned histologic features.

To the best of our knowledge, we present a novel clinicopathologic finding in yellow facial papules consisting of histologically hypertrophic sebaceous glands lacking associated vellus hair follicles.

Of 108 patients with FFA followed at a single dermatology center between January 2009 and December 2016, 62 patients exhibited yellow facial papules. From this sample, 10 cases with clinical and histologic documentation were reviewed: 9 white women (6 premenopausal) and 1 man, with a mean age of 44.5 years (range, 29–60 years) and a median duration of FFA of 12 months (range, 0–132 months). Yellow papules were found on the temporal area ( $n = 3$ ), cheeks ( $n = 1$ ), chin ( $n = 2$ ), or diffusely distributed throughout the face ( $n = 4$ ). Histopathologic findings were invariably similar, with hypertrophic sebaceous glands in the papillary dermis with no associated vellus hair follicle or lichenoid inflammation (Fig 1). This observation led us to hypothesize that inflammation eventually resulted in the loss of vellus hair follicles replaced by fibrous scar tissue, whereas the hypertrophic sebaceous glands still remained, giving the clinical appearance of yellow noninflammatory papules on the face devoid of terminal hairs. In all of these patients, the skin was clinically very soft and thin, which made the hypertrophic sebaceous glands shine through. Other authors reported that they

had seen these papules disappearing over years, leaving smoother skin without visible follicular orifices.<sup>6</sup>

There is no standardized treatment for FFA, and distinct FFA signs may be managed by targeted therapy. Based on the described clinical and histologic correlation of yellow facial papules, we have added oral isotretinoin, 10 mg every other day, to the oral therapy scheme (finasteride 2.5–5 mg/day or spironolactone 25–50 mg/day for females and vitamin supplements plus pimecrolimus cream) for these 10 patients with FFA. Overall, and although we acknowledge the relatively low number of patients, oral isotretinoin yielded a visible reduction of the yellow facial papules associated with an improvement of skin “roughness” reported by the patients after a median time of 2 months and clinically observed after a median time of 4 months (Fig 2). This treatment was usually extended for  $\geq 12$  months, with no reports of hair loss increase.

In conclusion, the presented data report a novel histologic finding in yellow facial papules, which probably represents an intermediate step between the initial lichenoid inflammation<sup>5</sup> and the ultimate skin atrophy without hair follicles.<sup>6</sup> This finding may have an impact on therapy, because low-dose isotretinoin resulting in sebaceous gland shrinkage could be a valuable option to improve cosmetic appearance in these cases.

Ana Filipa Pedrosa, MD,<sup>a,b,c</sup> Ana Filipa Duarte, MD,<sup>a</sup> Eckart Haneke, MD, PhD,<sup>a,d</sup> and Osvaldo Correia, MD, PhD<sup>a,b</sup>

Centro de Dermatologia Epidermis,<sup>a</sup> Instituto CUF, Faculty of Medicine,<sup>b</sup> University of Porto, and Department of Dermatology and Venereology,<sup>c</sup> Centro Hospitalar São João EPE, Porto, Portugal; and the Department of Dermatology,<sup>d</sup> Inselspital, University of Bern, Bern, Switzerland

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*Correspondence to:* Ana Filipa Pedrosa, MD, Centro de Dermatologia Epidermis, Instituto CUF, Rua Fonte das Sete Bicas, 170, Porto, Portugal

*E-mail:* [anabastospedrosa@gmail.com](mailto:anabastospedrosa@gmail.com)

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## Clinical and pathologic factors associated with deep transection of biopsies of invasive melanoma



*To the Editor:* The strongest predictor of melanoma survival is Breslow tumor thickness,<sup>1</sup> which dictates the margins for wide local excision and whether sentinel lymph node biopsy is performed.<sup>2</sup> If the skin biopsy of a melanoma is deeply transected, then the true Breslow depth is not known. The 2012 National Comprehensive Cancer Network Clinical Practice Guidelines for melanoma recommends that sentinel lymph node biopsy be considered in stage 1A melanomas ( $\leq 1$  mm thick, no ulceration, mitotic rate  $< 1$  per mm<sup>2</sup>) in which deep biopsy margins are positive.<sup>2</sup> Therefore, patients may undergo sentinel lymph node sampling solely because of deep transection. Studies have demonstrated deep transection rates ranging from 6.7% to 43%.<sup>3-5</sup> However, little information is available in the literature on the characteristics associated with deep transection. A preliminary review of melanoma biopsies at our academic community revealed a deep transection rate of 31%. The aim of this study was to identify factors associated with deep transection to ultimately reduce this rate of deep transection.

A retrospective chart review was performed of patients diagnosed with invasive melanoma between July 1, 2007, and June 30, 2012, from dermatology clinics at the University of Utah in Salt Lake City, Utah. Data from chart review included a variety of clinical and pathologic characteristics. A total of 307 melanomas were identified and met study criteria. Thirty percent of melanoma biopsies were deeply transected. Table I describes the clinical and pathologic characteristics for deeply transected invasive melanoma biopsies compared with non-transected biopsies. Univariable and multivariable mixed-effects Poisson regressions for binary outcomes (Table II) were performed to adjust for the provider's influence on the biopsy outcome and to account for nesting of patients within providers.<sup>6</sup> The factors significantly associated with deep transection in the univariable Poisson regression included female sex, shave biopsy (over punch and excisional), biopsy site of ear and digit (over other locations), melanoma types of nevoid, acral lentiginous, and nodular (over superficial spreading, lentigo maligna melanoma, and other), shallower biopsy depth, deeper Breslow depth, presence of ulceration and mitoses, lack of clinician concern for melanoma, and whether the visit was the first with the provider. Melanoma type and presence of ulceration or mitoses were dropped from the multivariable analysis because of lack of significance.

This study demonstrates a rate of deep transection similar to that of other studies with comparable populations.<sup>4,5</sup> The most significant predictor of biopsy transection in the multivariable model was the use of shave biopsy. Excisional biopsy is the recommended method for biopsy of melanoma, but a deep saucerization is considered satisfactory with flat lesions when concern for melanoma is low.<sup>2,7</sup> However, the average gross biopsy depth of 1.6 mm for transected lesions suggests that saucerization was not the intent of these shave biopsies. Shallower biopsy depth and higher Breslow depth, as one would expect, were associated with deep transection. The association with lack of clinician concern for melanoma implies that clinicians may be under-recognizing melanoma, which may in part explain less aggressive biopsy techniques. One may speculate that the association with biopsy sites of the ear and digit may reflect the technical difficulty of performing punch or excisional biopsies in these locations compared with other sites. It is unclear why female sex or first visit with the provider were associated with deep biopsy transection. The aggressive melanoma subtypes and presence of ulceration and mitoses may have lost significance in the