

## WHAT IS THE DIAGNOSIS

# Indurated plaque with zosteriform distribution in lumbar region of nursing patient

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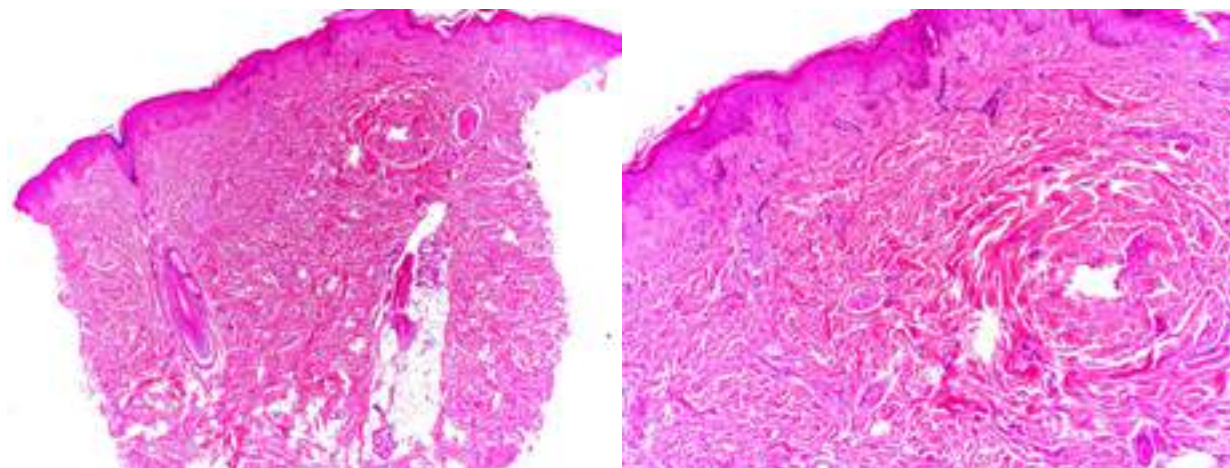
## CLINICAL PRESENTATION

1 year old and 6 months of age patient, with unknown medical pathological history, presents with clinical picture of 1 year of evolution, characterized by multiple skin-colored papules, with mamelonated surfaces converging and forming poorly defined plaque, measuring approximately 6 cm in diameter, covered by hair, of soft consistency, and zosteriform arrangement located in the left lumbosacral region, occasionally presenting with sporadic pruritus; no apparent pathological data is revealed on physical examination.

A biopsy of such lesion is performed, evidencing skin with partially preserved architecture and proliferation of dense, adipose collagen tissue, accompanied by slightly congested capillaries. No atypia or signs of malignancy.



Clinical dermatoscopy.



Histology.

## DISCUSSION

In relation to the clinical characteristics and histopathological findings, the diagnosis was confirmed as connective tissue nevus. Due to the variety of syndromes including this type of nevi, the patient underwent a series of procedures, such as bone radiographic evaluation of thorax, pelvis and limbs, electrocardiogram, as well as laboratory studies, including renal function, serum calcium and phosphorus, along with a complete clinical examination of family members; their results were normal.

Connective tissue nevi (CTN) are a rare form of heterotopia or benign, well-defined hamartomas of the dermis that originate from mesoderm cells; they are characterized by accumulation and abnormal distribution of extracellular matrix components: collagen, elastin or proteoglycans. Connective tissue nevi can be categorized according to the predominance of one of the aforementioned components. Despite the similar clinical appearance shared by many CTNs, they can be

differentiated histochemically and/or biochemically based on the present connective tissue primary element.<sup>1</sup> Zosteriform connective tissue nevus is a rare form of this type of heterotopia. Its diagnosis is essentially one of exclusion, based on the clinical distribution of the lesions; it may be sporadic or associated with entities, such as Buschke-Ollendorff syndrome, tuberous sclerosis, Proteus syndrome, or multiple endocrine neoplasia type 1 (MEN1).<sup>2</sup>

Clinically, they are composed of firm dermal papules or nodules that coalesce into plaques. They are generally skin-colored but may have a yellowish hue. In a Canadian series of 114 cases of CTN, most were found to be located on the trunk (55%), and/or the limbs (45%), with a small number in the head and neck (5%). 85% are solitary and 15% are multiple. It is difficult to estimate its incidence and prevalence because such lesions are asymptomatic. Consequently, they can be missed and underdiagnosed. The main differential diagnoses are superficial cutaneous nevus lipomatosus, granuloma annulare, morphea, anetoderma, and segmental neu-

rofibromatosis. The last differential possibility must be excluded due to its association with gliomas.<sup>3</sup>

Treatment will vary depending on the subtype of injury, as well as age, number and location of injuries, and accompanying syndromes. Injury monitoring may be appropriate if the injury is not bothersome and the location does not interfere with physical activities. Available therapeutic options are surgical excisions, dermabrasion and laser therapy. Alternatively, intralesional administration of steroids has also been suggested if surgery is not desirable or feasible. The intralesional use of triamcinolone at intervals of one month for one year has been reported, resulting in flattening, atrophy and depigmentation of the lesion without recurrence. This report was made after one year of follow-up, and was the therapeutic option in the present case with favourable evolution after 12 months.<sup>4</sup>

## REFERENCES

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1. Escutia B, Alfonso R, Carnero L, Durán R, Tudela J, Saki, N., Dorostkar, A., Heiran, A., & Sari Aslani, F. (2018). Satisfactory treatment of a large connective tissue nevus with intralesional steroid injection. *Dermatol Pract Concept* , 8 (1), 12–14.
2. Amjadi, M., Khorrami-Arani, N., Mashman, G., & Allen, P. W. (2007). Zosteriform Connective Tissue Nevus: A Case Report . *American Journal of Dermatopathology* , 29 (3), 303–305.
3. McCuaig , C. C., Vera, C., Kokta, V., Marcoux, D., Hatami , A., Thuraisingam , T., y otros. (2012). Connective tissue nevi in children: Institutional experience and review. *Journal of the American Academy of Dermatology* , 67 (5), 890–897.
4. Arora, H., Falto-Aizpurua, L., Cortés-Fernandez , A., Choudhary, S., & Romanelli, P. (2017). Connective Tissue Nevi: A Review of the Literature. *American Journal of Dermatopathology* , 39 (5), 325–338.