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Red Dots in a Net-Like Pattern on the Upper Chest: A Novel Clinical Observation in Frontal Fibrosing Alopecia and Fibrosing Alopecia in Pattern Distribution

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To the Editor,

Frontal fibrosing alopecia (FFA) and fibrosing alopecia in pattern distribution (FAPD) are 2 presentations of scarring alopecia involving the frontal and centroparietal scalp, respectively, which share similar clinical and pathologic findings. Loss of follicular openings with perifollicular erythema and follicular hyperkeratosis are noted in the frontotemporal scalp in FFA and in an androgen-dependent distribution of the centroparietal scalp in FAPD. The hair loss in FFA can be more generalized, involving the eyebrows, sideburns, limbs, and other body areas [1]. Facial lesions have been reported in patients with FFA consisting of noninflammatory, skin-colored papules [2–4], perifollicular or diffuse erythema [2], glabellar red dots [1], progressive pigmented macules, and lichen planus pigmentosus [2]. Ramanauskaite and Trüeb [5] reported a case of skin-colored facial papules attributing to roughening of the skin in a patient with FAPD. More recently, a case of extrafacial follicular red dots was described in a patient with FFA [6]. We describe extrafacial red dots presenting as perifollicular and diffuse erythema on the upper chest in 2 females with biopsy-proven diagnosis of FFA and FAPD, and we provide dermoscopic and pathologic correlation.

A 65-year-old female of the Fitzpatrick skin type II presented for follow-up of biopsy-proven FAPD of 12 months' duration affecting the centroparietal scalp and eyebrows. She has been treated with topical steroids and minoxidil while pending hydroxychloroquine initiation. At this visit, she complained of pruritic red dots on her chest of recent onset and denied any unprotected sun exposure. Physical examination revealed a diffuse reticulated network of erythematous macules spread over the upper chest (Fig. 1a). On dermoscopy, the lesions showed central, dusky, red blotches with branching interconnecting fine capillaries (Fig. 1b). A biopsy from a red dot showed interface dermatitis with a band-like lymphocytic infiltrate involving the interfollicular dermis and individual necrotic keratinocytes in the epidermis. Telangiectatic capillaries were appreciated (Fig. 1c). Diagnosis of extrafacial red dots in a

net-like pattern on the chest was made, and the patient was started on pimecrolimus cream.

Another 52-year-old female of the Fitzpatrick skin type II presented for follow-up for biopsy-proven FFA of 3 years' duration, involving the frontal and temporal scalp, sideburns, eyebrows, and limbs. The patient has been well maintained on pimecrolimus cream, oral finasteride 2.5 mg daily and topical minoxidil. She reported new onset of red dots on her upper chest. She denied sun exposure. Physical examination revealed pink-red telangiectatic macules forming a reticulated network (Fig. 2). Dermoscopy was consistent with the previous case. The patient was hesitant to undergo a skin biopsy in that area and was instructed to use pimecrolimus cream.

Discussion

Pirmez et al. [1] first reported the presence of follicular red dots on the forehead in 6 patients with FFA, which were either localized in the glabellar region ($n = 5$) or more diffusely on the forehead ($n = 1$). The pathology was consistent with a lichenoid lymphocytic infiltrate of the vellus follicles. However, our findings are most consistent with the work of López-Pestaña et al. [2] who described 9 patients with FFA presenting with perifollicular erythema of the forehead, glabella, eyebrows, and cheeks, with clinical images that are similar to the red dots in the net-like pattern on the chest seen in our 2 patients. In fact, their pathologic Figure 3b is identical to our pathologic findings, highlighting an interfollicular lichenoid infiltrate [2].

The chest is a common location for actinic damage, which presents with similar clinical findings. However, the abrupt onset of the lesions, accompanied pruritus, lack of a history of sun exposure, and the presence of a band-like lichenoid infiltrate in the histology distinguishes the extrafacial red dots in the net-like pattern from sun-induced poikiloderma of Civatte. In fact, both patients admitted regularly using sunscreen on the upper chest for years, which is curious because a possible association between FFA and the use of facial skin care products containing sunscreens has been recently suggested [7]. The overlap of FFA and discoid lupus erythematosus has been described in the scalp [8] and was considered in the differential diagnosis of our cases; however, the clinical and pathologic findings excluded discoid lupus erythematosus, and serology was negative for antinuclear antibody and single-stranded DNA. Direct immunofluorescence was not performed due to cosmetic concern of another biopsy scar.

A possible speculation linking the clinical appearance of red dots in a net-like pattern and the pathologic findings of lichenoid dermatitis is that this clinical feature might be an early manifestation of lichen planus pigmentosus. As previously described [9, 10], lichen planus pigmentosus in FFA patients may display affected areas other than the face, such as the neck and cleavage area. The reticular pattern presented on dermoscopy is reminiscent of the reticulated pattern described for lichen planus pigmentosus. In ad-

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Fig. 1. **a** Red dots in a net-like pattern on the upper chest of Patient 1. **b** Dermoscopy showing red blotches (black arrows) with emitting branching interconnected fine capillaries in Patient 1 (Handyscope, $\times 20$; FotoFinder, Bad Birnbach, Germany). **c** Biopsy specimen from the chest of Patient 1 showing interface dermatitis with a band-like lymphocytic infiltrate in the interfollicular dermis, individual necrotic keratinocytes in the epidermis, and the presence of telangiectatic capillaries (hematoxylin and eosin, $\times 10$).

Fig. 2. Red dots in a net-like pattern on the upper chest of Patient 2.

dition, López-Pestaña et al. [2] reported on a patient who presented with an erythematous network on the face that gradually evolved into a pigmented network.

In conclusion, extrafacial red dots in a net-like pattern on the chest are a new presentation of FFA and FAPD, which needs further validation in larger groups of patients.

Statement of Ethics

Patient consent was given.

Disclosure Statement

All authors deny any potential conflicts of interest, sources of funding, and/or other relationships requiring disclosure.

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