is not clear why catagen/telogen-phase follicles are preserved in other cicatricial alopecias, because destruction of the bulge zone is a common final outcome.

In conclusion, loss of CK15 expression is not a unique feature of LPP, being also present in LE and FFA. Loss of CK15 expression reflects a nonspecific destruction of the bulge area even in diseases not specifically targeting the follicular bulge stem cells and should not be used as a diagnostic clue in favor of LPP. It would be interesting to further explore CK15 expression in other scarring alopecias affecting the superficial portion of follicles, such as central centrifugal cicatricial alopecia and folliculitis decalvans.

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Brown globules in lentigo maligna (LM): A useful dermoscopic clue

To the Editor: Lentigo maligna (LM) is a slow-growing in situ melanoma commonly located on chronically sun-exposed skin. Females are more frequently affected than males, with a peak of incidence at the seventh and eighth decade of life. Clinically, LM appears as a solitary, asymmetric patch or plaque with irregular borders and variegated colors. Clinical differential diagnoses include mainly solar lentigo, pigmented actinic keratosis, and lichen planus–like keratosis. Several dermoscopic features characterize these lesions, however some overlapping dermoscopic criteria make the diagnosis of LM in its initial phase very challenging.[1-4] In equivocal cases, biopsy and histopathologic examination remain the gold standard for the diagnosis.

We describe 6 cases of facial LM characterized by brown dots/globules as the main melanocytic dermoscopic feature included in a series of 122 LM/lentigo maligna melanoma (LMM) collected from 2005 through 2010. Six LM lesions of 6 patients, 4 female and 2 male, aged 54 to 66 years (mean 60 years), were located on the ear (n = 3), neck (n = 1), cheek (n = 1), and temporal region (n = 1). In all lesions, dermoscopic examination showed light- to dark-brown irregular dots/globules and a light-brown structureless background pigmentation as the predominant features (Fig 1, *A*). Few annular-granular structures were observed in 1 of 6 cases and blue-gray granules in another case. Histopathologic examination showed in all cases a proliferation of single atypical melanocytes along the basal layer of the epidermis and down the adnexa combined with the presence of junctional nests. In 2 cases, junctional nests were prevalent over the lentiginous pattern (Fig 1, *B*).

Dermoscopy of LM was initially described by Schiffner et al[1] who proposed a progression model from the early phase of LM, characterized by dots aggregated around follicles, asymmetric pigmented follicular openings, and streaks, to an intermediate phase displaying annular-granular structures and rhomboidal structures until the invasive LM showing homogeneous areas and obliterated hair follicles. Recently, 4 new dermoscopic criteria to diagnose LM have been described: darkening at dermoscopy, increase of vascular density, red rhomboidal structures, and targetlike pattern.[2] Only the presence of homogeneous areas with obliterated hair follicles is considered highly specific of invasive LM, whereas the other criteria (asymmetric pigmented follicular openings, annular-granular pattern, and rhomboidal structures) can be also found in pigmented actinic keratosis, lichen planus–like keratosis, and solar lentigos.[3-5]

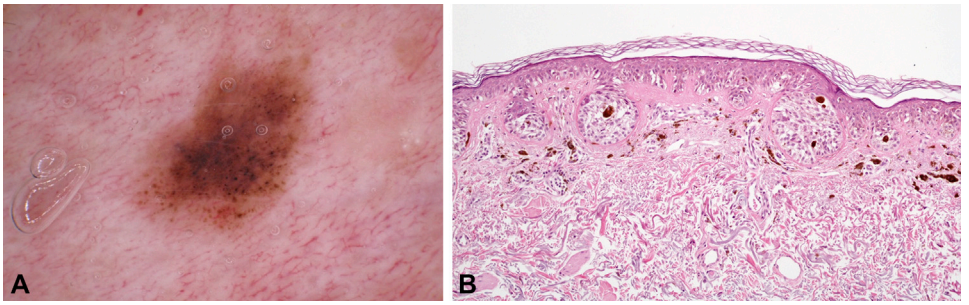

Fig 1. Lentigo maligna on the face of a 54-year-old woman. **A**, Dermoscopic examination showed light- to dark-brown dots/globules irregularly distributed throughout the lesion, a light-brown structureless background pigmentation, and few blue-gray granules. **B**, Histopathologic examination revealed the presence of junctional nests of atypical melanocytes with a cannonball-like appearance together with atypical lentiginous proliferation in single units. Melanophages and solar elastosis can be found in the superficial dermis.

In this study, we describe the combination of light- to dark-brown irregular dots/globules associated with brown background pigmentation as the predominant dermoscopic clue of LM. Irregular brown dots/globules, which are typically observed in extrafacial melanoma, have been also described in approximately 10% of facial LM.[2] The clinical, dermoscopic, and histopathologic features observed in our series are similar to those reported by Longo et al[5] in 3 patients with nested superficial spreading melanoma located on the trunk and extremities. In such cases, dermoscopy showed pigmented globules irregular in size, color, and distribution, and a light- to dark-brown structureless background; histopathologic examination showed a junctional melanocytic proliferation with predominant nested pattern.

In conclusion, we described 6 cases of facial LM dermoscopically characterized by irregular dots/globules and brown background pigmentation, suggesting that such features should serve as an alert to the diagnosis of LM. However, the sensitivity of this clue was low in our study and further research is needed to verify its specificity.

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Lesions referred to dermatology in the Department of Veterans Affairs (VA) health system: A retrospective chart review

To the Editor: Skin lesions sent to dermatology by primary care physicians (PCPs) represent a significant proportion of visits in the Department of Veterans Affairs (VA) Health System. Previously we reported a per-person incidental (ie, lesion was not mentioned in consult) malignancy detection rate of 6.9% (1187/17,174)[1] and an incidental melanoma detection rate of 0.5% (84/17,174).[2] The study herein characterizes lesions identified by PCPs in these consults.