

tion with occult bronchogenic carcinoma and perhaps other malignancies seems undeniable; improvement in the keratoderma following treatment of the lung lesion has been reported (10). The development of acquired keratoderma should consequently prompt thorough investigation for the possible presence of occult neoplasm.

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Cartilaginous Nevus on the Glabella

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Abstract. Cartilaginous nevus usually occurs in front of the auricle as an accessory auricle and much less frequently on the cheek or anterior part of the neck. We report a case of cartilaginous nevus found on an unusual location, the glabella of the face, in an otherwise normal newborn girl. We think that it was a remnant of the branchial cartilage derived from the first pharyngeal arch of embryonic life.

Key words: Cartilaginous nevus; Developmental anomaly; Glabella

CASE REPORT

A newborn girl was referred to us because of a pedunculated nodule on the glabella. The baby, being otherwise normal, was a second daughter of healthy parents. The delivery was normal after an uneventful pregnancy. There was no family history of developmental or cutaneous malformation.

The nodule was elastic-soft, pedunculated, 3 mm in diameter and 4 mm in height, being located on the glabella (Fig. 1). It was excised totally under local anesthesia and processed for histologic examination. Sections stained with hematoxylin-eosin showed an unremarkable epidermis but there was cartilaginous tissue in the deep portion of the dermis (Fig. 2).



Fig. 1. A pedunculated nodule on the glabella.

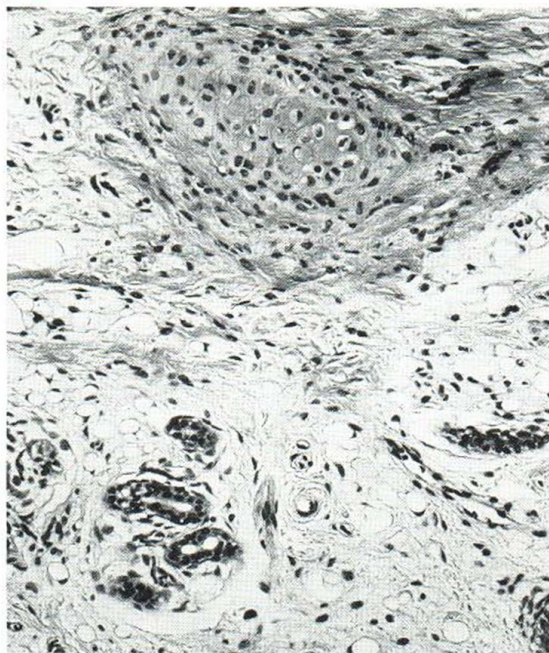


Fig. 2. Cartilaginous tissue in the deep portion of the dermis (hematoxylin-eosin, $\times 200$).

DISCUSSION

Cartilaginous nevus is regarded as arising from the abnormal development of the auricular tubercles or from the tissues surrounding the second, third and fourth branchial clefts (2). Major features of the facial structure are established until the end of the second month of the embryonic life (1) and the most frequent location of cartilaginous nevus is the line of junction of the first and second pharyngeal arches. Less frequently it occurs in the line of junction of the maxillary and mandibular processes, i.e. on the cheek between the auricle and the angle of the mouth (3). Therefore, our case is peculiar because of its location and we were unable to find a similar case in the literature.

Since the facial musculature arises from the first pharyngeal arch (1), we think that the cartilaginous tissue found in the glabella in the present case was a remnant of the branchial cartilage that is derived from the first pharyngeal arch at the time of the differentiation of the facial muscles.

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A Novel Wax Stick Preparation of Anthralin¹

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Abstract. A new wax formulation of anthralin was compared with anthralin as used in the Ingram regimen for the treatment of chronic discoid psoriasis. In 16 out-patients 12 of the 13 who responded to the Ingram regimen also showed a satisfactory response to the wax preparation. The latter could be applied more rapidly and simply and may thus have a useful place in the domestic management of chronic psoriasis.

Key words: Anthralin; Chronic psoriasis; Home use

Anthralin is the major active component of the Ingram regimen (2) now widely used for the topical treatment of chronic psoriasis. Used as it is in stiff Lassar's paste it is both messy and time-consuming to apply and must be removed after each treatment. Few patients are able to use the paste successfully at home and several attempts have been made to produce an anthralin application suitable for home use (1, 3). A recent introduction is a wax preparation of anthralin which is held like lipstick in a retractable container for ease of application (see illustration). The wax sticks contain 0.5%, 1% or 2% anthralin with salicylic acid as a stabilizer.

We have carried out small pilot studies in out-patients and in in-patients to compare the new preparation with anthralin in Lassar's paste.

¹ Anthraderm, pHarma-medica; Antraderm, Brocades Ltd.