Correspondence

Actinic comedonal plaque

To the Editor:

The article by Jerome S. Eastern and Sandy Martin, "Actinic Comedonal Plaque," which appeared on page 633 of the December, 1980, issue of the JOURNAL, reminded me of lesions we see not uncommonly in our laboratory; our clinical colleagues have called them "coral reef granuloma" because of their macroscopic appearance.[1] Included in this "entity" are cases with dermal microabscess formation and draining sinuses of the type reported by Su, Duncan, and Perry as "blastomycosis-like pyoderma"[2]; they are frequently related to chronic infection with *Staphylococcus aureus*. At the other end of the spectrum are cases resembling those described recently as "actinic comedonal plaques." In our experience, many of these cases have a preceding inflammatory phase resembling blastomycosis-like pyoderma, but usually less florid. Furthermore, such lesions invariably arise in actinically damaged skin, particularly the forearm. Staphylococci have sometimes been cultured from biopsy material in cases in which cultures taken from the surface have been negative. This is our justification for including these two types of lesions under the heading "coral reef granuloma."

I would be interested in learning whether the authors found foci of suppuration in any of their cases, particularly Case 5, which appears to be a much more inflammatory lesion than the others pictured.

We have seen a lesion resembling those described as actinic comedonal plaque at the edge of a tattoo, although a similar case described by Yaffee[3] was more inflammatory, in keeping with the descriptions of blastomycosis-like pyoderma. This is further circumstantial evidence for regarding actinic comedonal plaque and blastomycosis-like pyoderma as related conditions. Factors such as the virulence of the staphylococci, the immune status of the patient, and the degree of actinic damage may modify the clinicopathologic appearances. Of interest is the recent report of diminished immune responses in sun-damaged skin.[4]

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To the Editor:

The article by Drs. Eastern and Martin on "Actinic Comedonal Plaque" is of great value in focusing attention on a special morphologic change which appears on the sun-damaged elastotic skin of the elderly. It is essentially an irregular scar, and, although it probably could follow as the end result of various destructive lesions affecting the elastotic skin, the most common cause of this type of scar in Australia is a preceding chronic pyoderma with multiple foci of discharge leading to irregular scarring.

This type of chronic pyoderma is well known to dermatologists in Australia under the misnomer "coral reef granuloma." It is not only described but also very well illustrated in the *Introduction to Dermatology* written by one of the great dermatologists of Australia, Dr. E. H. Molesworth, in the second edition of his book.[1] On page 107, he not only described the condition as: the typical "coral reef" or "honeycomb" scar "which remains to mark the area of invasion" of the chronic pyoderma, but also very well illustrated it. Under Fig. 15, appearing on the same page, we read: "Coral reef cicatrix of agminate staphylococcal folliculitis." Later, Australian dermatologists[2,3] misnamed this type of pyoderma "coral reef granuloma," meaning a type of chronic pyoderma arising on the elastotic skin.

While the lesion remains active, it discharges pus from many openings. When the pyoderma heals, the characteristic scar remains, as illustrated in the photograph of a patient seen by me about fifteen years ago (Fig. 1). This special morphologic aspect of the scar is due to the brown-yellow papules and ridges formed by the remnants of the superficial elastotic layer which remained from the diffuse elastosis and were caught up by the scarring process. As my illustration shows, the comedo is not always present at the late stages of the scar formation.

May I propose, in honor of a great Australian der-