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Histologic persistence of a congenital melanocytic nevus of the scalp despite clinical involution

To the Editor: We read with great interest the article by Strauss and Newton Bishop[1] in the March 2008 issue of the *Journal* regarding spontaneous involution of congenital melanocytic nevi of the scalp. They reported five cases of melanocytic nevi more than 5 cm in diameter in five newborns that faded progressively before the age of 4 years (11-48 months; mean age, 26 months), leaving only a slightly darker skin color in three of the cases. No skin biopsies were carried out to confirm disappearance of the nevus.

We report similar findings in two children in whom medium to large congenital nevi more than 5 cm in diameter on the temporal and parietal scalp disappeared clinically before 24 and 48 months of age, respectively. There were no satellite lesions. Magnetic resonance imaging did not show neurocutaneous melanosis in either patient, and they were otherwise healthy. The congenital nevi in both children faded over time until they clinically disappeared. Neither sclerodermoid changes,[2,3] a white halo, nor distant leukoderma were observed.

In one patient, the hair in the affected area remained darker in color, although the underlying skin looked normal. A skin biopsy was performed. This showed persistence of the congenital melanocytic nevus deep in the dermis and extending to the subcutaneous fat and pilosebaceous units, without apparent destruction of the nevus cells, inflammation, or fibrosis.

This indicates that, despite the clinical disappearance of congenital melanocytic nevi, nevus cells may still be present histologically. This may have important consequences. Parents should be informed that, despite the apparent resolution, the potential risk of malignant transformation has not been completely eliminated. We do not know whether the clinically invisible nevus has a similar or lower risk of malignant transformation than that of a nonregressing congenital melanocytic nevus. Our findings suggest, however, that clinical follow-up should be continued.

Most regressed congenital nevi reported in the literature are on the scalp, and very few have been observed on other parts of the body.[4,5] We have no explanation for this. We agree with Strauss and Newton Bishop, who recommend that the cosmetic removal of these lesions should be delayed with close follow-up until 24 months of age to allow for the possibility of spontaneous improvement.

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Aqua lymphatic therapy for managing lower extremity lymphedema

To the Editor: We read with great interest the August 2008 article by Kerchner et al[1] entitled "Lower extremity lymphedema update: Pathophysiology, diagnosis, and treatment guidelines." The authors reviewed the pathophysiology, diagnosis, and treatment guidelines for lower extremity lymphedema. Management options that were mentioned included extremity elevation, exercise, compression garments, manual lymph drainage, skin care, surgery, and drug therapy.

We would like to call attention to a novel treatment approach, called aqua lymphatic therapy (ALT), that gives another treatment option for lymphedema patients.[2,3] It provides patients in the maintenance phase of lymphedema with the opportunity to treat them in a group setting once a week. Lymphedema must be treated on a daily basis; therefore, ALT is an active method performed entirely by the patient and not by the physical therapist. During the weekly group session, the physical therapist measures girth before and after each session to monitor the effectiveness of treatment and to enable patients to track and modify their individual maintenance plans. ALT uses the properties of water—buoyant force, hydrostatic pressure, water viscosity, and water temperature—to maintain or improve reductions in lymphedema that are achieved during intensive treatment phase.

The hydrotherapeutic pool has a graduated depth of 1.2 to 1.6 m. It is monitored for pH (7.02), chloride concentration, bacteriologic control, and water clarity. Participants with infections are not allowed to precipitate. Each session includes a few basic elements: (1) skin care—patients apply a silicone cream to protect the skin before each session; (2) manual massage—patients carry out self-massage and water massage; (3) compression—the hydrostatic pressure of water at 32°C gradually increases with greater depth; therefore, the limb benefits from pressure gradients, which influence the direction of lymphatic flow; and (4) exercise—exercises are carried out in the pool to allow the patent to benefit from the properties of the water itself. The viscosity of water provides resistance to body movement, which promotes strengthening and improves lymphatic clearance. Because water resists movement in any plane, a variety of limb movements may be used to offer differing pressures on the skin; this may improve pumping of the lymphatic vessels.

ALT endorses self-advocacy. It educates patients about a particular series of motions in order to reduce their edema and to take control of their own care. While learning and practicing this technique with others, they enjoy the advantages of being part of a support group that addresses qualitative issues.[3]

Further clinical research is needed to provide additional data on its usefulness in patients with lymphedema resulting from different medical conditions and to adjust the techniques for treatment of a variety of patient populations.

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The rapidly evolving role of anakinra in dermatology: A double-edged sword

To the Editor: I read with great interest the article by Regula et al[1] in the August 2008 issue of the *Journal*. The authors reported a patient with interstitial granulomatous drug reaction to anakinra. This is highly