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The Beak Sign: A Clinical Clue to Airborne Contact Dermatitis

To the Editor:

Airborne contact dermatitis results from exposure to allergen or irritant-inducing materials that have potential for transmission as dust, droplets, or gas.¹ Major airborne contact dermatitis agents include metals, organic compounds, chemical solvents, pesticides, and plant-derived substances (eg, tobacco smoke, fragrances).¹ Although definitive diagnosis requires exposure history and observation of unique dermatosis distributions, unpredictable dermatosis patterns and extensive irritant possibilities often confound even the most experienced clinicians.

We have encountered several patients experiencing airborne contact dermatitis who have demonstrated sparing of the nasal skin, providing a “beak sign” suggestive for airborne contact dermatitis. A 65-year-old African American male repeatedly visited our outpatient clinic with recalcitrant eczematous dermatosis affecting his scalp, cheeks, forehead, and the skin behind his ears and mastoid area with extension to his neck. Strikingly, the patient’s nose demonstrated a greasy appearance, which lacked any evidence of

his otherwise severe dermatitis (Fig. 1). A detailed history revealed his morning routine of standing in an aerosolized plume of deodorant fragrance, a practice that, when ceased, would lead to complete resolution of his dermatitis.

Similarly, a 72-year-old Indian male patient reported a 10-year intermittent dermatitis affecting his legs, arms, and face impervious to multiple trials of prescription and nonprescription immunomodulators. At presentation, the dermatosis involved his forehead, cheeks, chin, neck, and posterior auricular and mastoid area with notable sparing of the skin of the nose. The patient reported visiting a beauty store before his recent exacerbation, and he further revealed participation in religious services involving incense. Patch testing revealed reactions to balsam of Peru, cinnamon aldehyde, and fragrance mix, agents found in perfumes.

Our third patient, a 46-year-old veteran, presented with a chronic pruritic eczematous dermatitis affecting his face, upper chest, and dorsal forearms, again with relative sparing



FIGURE 1. A 65-year-old patient demonstrates facially distributed dermatitis with a prominent beak sign or sparing of the skin of the nose. History revealed aerosolized deodorant use. When ceased, his dermatitis resolves.

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of the nasal dorsum. We suspected airborne contact dermatitis with an atopic diathesis. Indeed, history revealed a habit of smoking vanilla-flavored cigars, and TRUE (SmartPractice, Hillerød, Denmark) patch testing showed a strong reaction to balsam of Peru.

Dermatitis of the upper eyelids, posterior auricular skin, mastoid and submental areas, and areas around the cuffs and collars offer clues to a diagnosis of airborne contact dermatitis.^{2,3} However, variable involvement of the cheeks and forehead may confound the diagnosis with photocontact and atopic dermatitis. In our experience, the beak sign (ie, the nasal ridge and/or tip sparing) in the setting of concordant history and positive skin patch testing may facilitate a diagnosis and effective treatment. Duly, a large prospective observational study may confirm or repudiate these initial observations. In our hypothesis, the beak sign may result from increased sebaceous gland concentration/activity preventing penetration of the outer epidermal barrier by aerosolized, water-soluble irritants. Regardless of the underlying mechanism, the beak sign may serve as an important clinical clue to the rapid identification and treatment of airborne contact dermatitis, and these observations warrant determination of the predictive value of this clinical sign.

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Benign Reactive “Reticular Telangiectatic Erythema” Mistaken for Cellulitis After Ventral Hernia Repair: A Report of 3 Cases in Which Mesh Was Used

To the Editor:

Currently, there are more than 200 various types of mesh available in the US market that surgeons can use to repair ventral incisional hernias.¹ Here, we highlight a benign cutaneous phenomenon, reticular telangiectatic erythema (RTE), that has recently been described with a variety of medical implantation devices including cardiac defibrillators, pacemakers, knee prostheses, spinal cord stimulators, and infusion pumps but has not yet been associated with mesh after hernia repair.^{2,3} Three cases illustrate RTE after repairs using mesh. They demonstrate the need for RTE to be in the differential diagnosis of presentations with erythema and pruritus surrounding the surgical site to avoid unnecessary clinical intervention.

A 77-year-old man had an asymptomatic, erythematous patch overlying his abdomen 4 months after laparoscopic ventral hernia repair with Surgimesh XB (Aspide Medical, St. Etienne, France) (a polypropylene mesh).^{4,5} The lesions were observed shortly after the procedure, and he was treated with intravenous antibiotics for presumed cellulitis without improvement. Physical examination showed erythematous, blanchable patches over the lower abdomen (Fig. 1).

A 70-year-old man had a mildly pruritic, erythematous patch on his abdomen after laparoscopic ventral hernia repair with Surgimesh XB. He noticed the lesions 2 weeks after the procedure. At follow-up examinations, no abatement of the lesion was observed.

A 69-year-old man had abdominal erythema 14 months after his fourth ventral hernia repair using 2 types of meshes; these are as follows: (1) Gore-Tex (W.L. Gore & Associates, Inc., Flagstaff, AZ) (mesh composed of polytetrafluoroethylene) for the first 3 procedures and (2) Surgimesh XB for his last repair. Because of concerns about skin infection, antibiotics were prescribed, but the erythema persisted.

Reticular telangiectatic erythema is a benign, reactive process that presents as a blanchable erythematous patch that evolves after implantation of medical devices, including cardiac defibrillators, pacemakers, knee prostheses, spinal cord stimulators, and infusion pumps.^{2,3} We describe 3 cases that

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