

which reflects the interaction between vascular structure and polarized light, has been observed in APACHE.^{1,5} Mercuri et al. observed a central pinkish-violet color, milky-red areas, and peripheral white halo along with irregular linear and hairpin vessels in a patient with multiple erythematous papulonodules over toes. The variation in dermoscopic features in their case may be because of the location (on the sole) and long duration (14 years) of the lesions. The dominant white color, peripheral white halo, and milky-red area observed by them is possibly because of the hyperkeratosis (visible in the histopathology image), and the irregular linear and hairpin vessels correlate to the dense dermal vascular proliferation.⁶ The other described dermoscopic features of APACHE include: pinkish-white area, irregular isolated linear vessels, a whitish scaly surface, and focal hemorrhagic crust.⁷

The dermoscopic features described for various vascular lesions that can mimic APACHE are: solitary angiokeratoma (dark and red lacunae, whitish veil, erythema, and hemorrhagic crusts),⁸ infantile hemangioma (polymorphous vascular structure, red linear lines, and dilated vessels),⁹ and pyogenic granuloma (red homogenous area surrounded by a white collarette, white rail lines, and vascular structures).¹⁰

In conclusion, in the appropriate clinical setting, the presence of a yellow-orange homogenous area with red-to-pinkish clods should prompt the clinician to consider a differential diagnosis of APACHE.

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Allergic connubial contact dermatitis caused by molybdenum from fiberglass

Dear Editor,

A 34-year-old nonatopic woman, phototype II, housewife, was referred to our Contact Eczema Department with a pruritic and eczematous eruption on both upper limbs developing over the last 8 months. The patient had no personal history of interest. Her husband works in a company of fiberglass manufacturing. She reported that after work, he comes home with clothing impregnated with dust and that contact with it was associated with intense itching.

On physical examination, a symmetrical eczematous rash was observed on the forearm and antecubital fossa (Fig. 1a,b), dorsum of the hands (Fig. 1c), and ventral aspect of the wrist (Fig. 1d). Patch tests were performed with the European Comprehensive Baseline Series (Chemotechnique Diagnostics, Vellinge, Sweden) and metal series (Chemotechnique Diagnostics). The results were interpreted according to the criteria of the International Contact Dermatitis Research Group. Patch tests were read on day (D)2 and D4. The patient showed a positive patch test reaction to molybdenum 5% pet. Skin stripping technique was negative. Skin biopsy showed mild acanthosis, spongiosis, and superficial lymphocytic infiltrate; it did not show fiberglass particle, and polarized light histological examination was negative.

Allergic connubial contact dermatitis caused by molybdenum was diagnosed. We indicated allergen avoidance measures and topical application of methylprednisolone aceponate cream one time a day for 7 days. Her husband did not come home with work

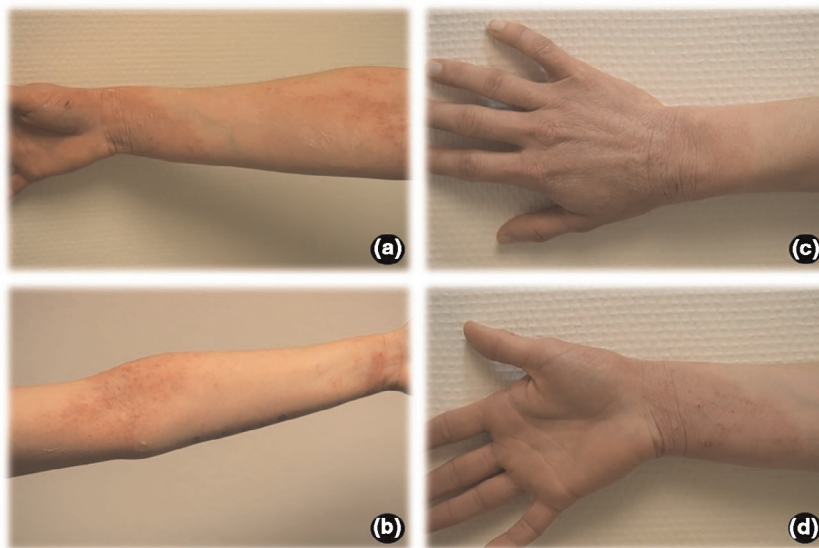


Figure 1 (a, b) Symmetrical eczematous eruption on the forearm and antecubital fossa. (c) Eczematous plaque on the dorsum of the hand. (d) Eczematous plaque on the ventral aspect of the wrist

clothes. The examination after 2 months showed a complete improvement of the lesions, without any treatment.

Fiberglass is a widely used material in the manufacturing industry for thermal and electrical insulation, and plastic reinforcement. The small fiberglass particles may induce several skin diseases, mainly contact dermatitis, which may cause intense pruritus.¹ The fiberglass microfibers are coated with resins, such as epoxy resin, and metals, such as molybdenum, that can cause allergic contact dermatitis. Molybdenum has the sixth highest melting point of any element, and for this reason, it is often used in high-strength steel alloys, such as dental alloys, for its high corrosion resistance and weldability. Most high-strength steel alloys are 0.25–8% molybdenum. There are few reported cases of molybdenum allergic contact dermatitis in the literature. Coronary stent² and orthopedic prostheses³ are the main sources of molybdenum awareness. Molybdenum electrodes have good behavior at high temperatures, corrosion resistance, and good electrical and thermal conductivity, often as a heating material widely used in the daily use of glass, optical glass, insulating materials, fiberglass, and rare earths. Molybdenum electrode is mainly manufactured by powder metallurgy method. The high-density molybdenum electrodes can help to extend the life of the furnace and electrode, and provide less erosion by molten glass.

Face, skin folds, hands, and forearms are the main areas affected in contact dermatitis from fiberglass. This location can be confused with atopic dermatitis. Atypical presentation, such as prurigo nodularis⁴ and granulomatous periorificial dermatitis,⁵ induced by fiberglass, has been reported. The fiberglass particles can be spread through laundering of contaminated clothes, which not only affects the patient but can also affect the family.

Connubial contact dermatitis should be suspected in family settings with risk professions, such as fiberglass workers. Fiberglass dermatitis diagnosis can be confirmed with skin biopsy and polarized light histological examination, or more recent *in vivo* reflectance confocal microscopy. Nevertheless, patch testing can be useful. Knowing the exact composition allowed us to focus on the study using patch tests, avoiding invasive procedures such as skin biopsy.

We present an interesting case of allergic connubial contact dermatitis caused by molybdenum from fiberglass. Sometimes these patients can be misdiagnosed as atopic dermatitis. The anamnesis of both the patient and the environment is crucial to correctly focus the study of patch tests.

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Readability, quality, and timeliness of online health resources for rosacea

Dear Editor,

Rosacea is a common, chronic inflammatory dermatosis affecting approximately 5.5% of adults globally.¹ Low health literacy is a known barrier to patient education and improved disease outcomes. With 80% of internet users searching online for health information, dermatologists should be aware of the accessibility and readability of rosacea-related online health resources to mitigate health disparities.² The American Medical Association recommends patient reading material to be ≤ 6 th grade reading level, but the readability and quality of online rosacea content are unknown. We investigated the readability and quality of content provided by top websites for rosacea-related patient information.

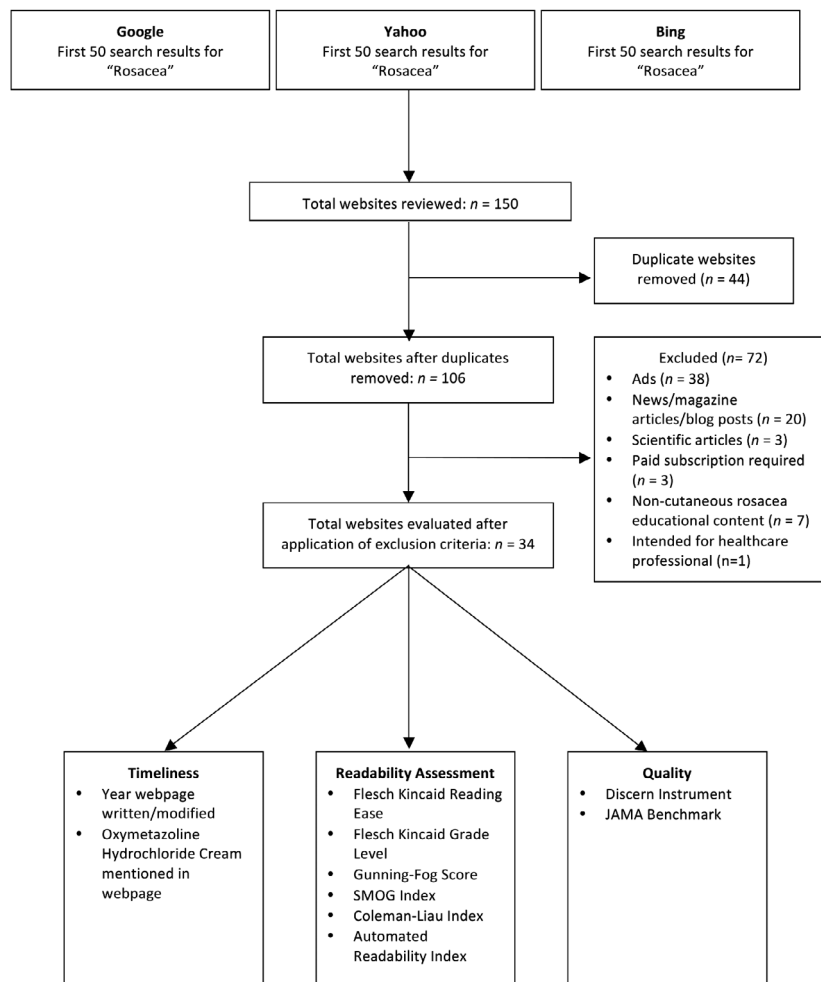


Figure 1 Schematic depicting selection and assessment of top searched patient education websites on rosacea