Case Report -

A male patient, aged 38, residing at Kamptee, Nagpur, presented to us with hyperpigmented lesions on neck (fig. 1), axillae (fig. 2) and cubital fossa (fig. 3) for last 4 years. Pitted scars were present on upper part of back and face (fig. 4 & 5). Patient reported similar clinical condition of his father and brother. For variety of reasons these relatives had not been submitted to clinical evaluation.

Biopsy was performed from hyperpigmented macule on axillae which showed acanthosis, hyperkeratosis, increased pigmentation of basal layer and slight digitation of rete ridges (fig. 6). The outcome of the clinical and histopathological test pointed conclusively to Dowling Degos disease.

Discussion -

Dowling Degos disease (DDD) is a late onset genodermatosis. The reticulate hyperpigmentation is admixed with and sometimes composed of lentigo-like brown macules; small brown papules with variable hyperkeratosis may also develop. These findings progressively increase over time, initially appear in axillae and groin with later involvement of intergluteal and inframammary folds, neck, trunk and inner aspects of arm and thighs. Some patients report pruritus of affected flexural areas. Comedo-like lesions on back and neck, pitted perioral scars, epidermoid cysts, hidradenitis suppurativa represent additional features in some patients. Histopathological finding of the disease include moderate orthokeratosis or hyperkeratosis, thinning of suprapapillary...
epithelium and elongation of papillae with basal layer hyperpigmentation. These thread like growth of epidermis have the appearance of “antlers” and generally involve the follicle with follicular plug. A perivascular lymphohistiocyte infiltrate in papillary dermis and pseudo horny cysts can also be observed.¹

**Differential Diagnosis**

Acanthosis nigricans is distinguished clinically by velvety plaques and histopathologically by less pronounced elongation of rete ridges, in addition there is no follicular involvement.¹

According to few literatures Acropigmentation of kitamura, Galli Galli disease and Habers disease are considered as differential diagnosis of DDD.¹⁵

Reticulate acropigmentation of kitamura (RAPK) is sporadic autosomal dominant disease of unknown origin, clinical features consists of hyperpigmented atrophic macules on dorsum of hands and feet. It onset in childhood. The lesion darken with time and worsen with sun exposure. Pitting on the palm and sole and dorsa of fingers can also be found.¹⁵

Galli-Galli disease is acantholytic varient of DDD which presents in people age between 15 and 56. Clinical symptoms includes presence of hyperpigmentation of flexures together with itching and sometimes with erythematous, scaly papules on these sites as well as on the trunk and proximal extremities. Histopathology resembles that of DDD but with foci of acantholysis.⁵

Harber’s disease is characterised by photosensitive facial rosacea-like rash which develops in adolescence, followed by the appearance of to keratotic papules, comedones-like lesion, cribriform scars, reticulate hyperpigmentation of trunk, proximal extremities and armpits.¹

A typical histopathological examination with compatible clinical features are enough for diagnosing DDD, as we did in this case.

Topical hydroquinone, tretinoin, adapalene and corticosteroids have been used with varying success. Improvement following treatment with the erbium : YAG laser also been reported.¹

**References**


**Conflict of interest** : Nil reported

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**Fig 1 : Hyperpigmented lesions on neck**
Fig 2: Hyperpigmented lesions in Axilla

Fig 3: Hyperpigmented lesions in Anticubital fossa

Fig 4: Pitted scars on back

Fig 5: Pitted scars on face

Fig 6: Histopathology of Macule showing:
Acanthosis, hyperkeratosis, increased pigmentation of basal layer and slight digitation of rete ridges