

## Melasma on the Nape of the Neck in a Man

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Sir,

We report a 47-year-old man with light brown macular pigmentation on the nape of his neck (Fig. 1). It was asymptomatic and had developed gradually over 2 years. He worked outdoors as a pipe fitter on an oilrig module; however, he denied exposure at this site because he always wore a shirt with a collar that covered the affected area. However, on further questioning it transpired that he spent most of the day with his head bent forward. This reproducibly exposed the area of pigmentation with a sharp cut off inferiorly at the level of his collar. He used various shampoos, aftershaves and shower gels, but none was applied directly to that area. His skin was otherwise normal and there was no family history of abnormal pigmentation. Woods lamp examination showed the pigmentation extending onto the sides of his neck. Skin biopsy of the light brown pigmentation of the nape of the neck showed a normal epidermis with increased basal pigmentation and normal numbers of melanocytes. These findings are consistent with an epidermal type of melasma.

Melasma is an acquired hypermelanosis of the skin most commonly seen in women. Pigment may be epidermal, dermal or mixed type (1). The usual distribution patterns are centro-facial, malar or mandibular facial skin, although it has been described on the forearms in association with hormone replacement therapy (2). High oestrogen states, sunlight exposure, familial tendency and photosensitizing agents have been aetiologically implicated (3). Melasma is recognized in men although the contribution of hormone dysregulation in this group is uncertain (4, 5), and the influence of

sunlight and photosensitizing agents may be more relevant.

The differential diagnosis for pigmentation at this site includes Riehl's melanosis, Berloque dermatitis and poikiloderma of Civatte. Riehl's melanosis typically involves the face with a brownish-grey pigmentation; biopsy might be expected to show interface change and liquefaction basal cell degeneration with a moderate lymphohistiocytic infiltrate, melanophages and pigmentary incontinence in the upper dermis. It is usually associated with cosmetic use and may be considered synonymous with pigmented allergic contact dermatitis of the face (6, 7). Berloque dermatitis is considered to be caused by a photoirritant reaction to bergapentin; it may affect the sun-exposed areas of the face, neck and arms. There is usually an early inflammatory phase followed by hyperpigmentation. Histology may show an irritant response in the acute phase; however, older pigmented lesions show increased number and size of melanosomes, melanocyte hypertrophy with arborization of dendrites (8, 9). Poikiloderma of Civatte consists of a reticulate reddish-brown pigmentation, atrophy and telangiectasia typically affecting the lateral aspect of the cheeks and neck, and is most often seen in women. The aetiology is unknown but photosensitizing chemicals in perfumes and cosmetics have been implicated. Histology shows moderate thinning of the stratum malpighii, hydropic degeneration of basal cells and effacement of the rete ridges. In the upper dermis there is a band-like infiltrate of lymphocytes and histiocytes; there may also be pigmentary incontinence (10).

We are not aware of any previous reports of melasma at this site. We feel that this unusual distribution of melasma in a man may result in part from UV exposure and it may be that intermittent exposure to UV is more relevant than constant exposure, as the skin of the face and hands are spared. We also suspect that this may not be a rarity, but may pass unnoticed by patient and physician.



Fig. 1. Light brown macular pigmentation on the nape of the patient's neck.

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