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Disseminated Punctate Intraepidermal Haemorrhage: A Widespread Counterpart of Black Heel

Sir,

The appearance of petechiae in a patient is always a distressing event. However, there are banal causes of purpura, such as the one we report here.

CASE REPORT

An 80-year-old man was presented with decubitus ulcers. He had paraplegia secondary to severe osteoarthritis of the lumbar spine and usually stayed in bed barefoot. He had no signs of other diseases, in particular vascular or cardiac disease. On physical examination he was found to have numerous, well-demarcated petechiae disseminated on the dorsal and plantar aspects of both feet. Petechiae were also present on the toe webs. They were not palpable and, considering the petechiae's sharp margins and "superficial" appearance, we performed a light curettage, which detached them (Fig. 1). Biopsy of one of the lesions showed the presence of a subcorneal mass of eosinophilic amorphous material, close to acrosyringiums. This material stained blue-green with Patent blue V, favouring a haematic origin (1). Haemosiderophages were present, scattered on the papillary dermis. A haemogram was normal. When asked about previous trauma, the patient could only recall a difficult transportation from his home, with several sudden movements of his legs. The lesions disappeared spontaneously after 1 week.

DISCUSSION

The most frequent form of intraepidermal haemorrhage is "black heel", well known as a differential diagnosis of



Fig. 1. Punctate petechiae on the feet. Curettage of a lesion on the third toe has been performed.

pigmented lesions on the feet. Other forms of intraepidermal haemorrhage have been described, such as lesions similar to black heel, but located in other areas of the foot (2), or grouped palmar petechiae (3–5). The name "post-traumatic punctate haemorrhage" has been proposed as a unifying term (5). Other related lesions are subungueal splinter haematomas, black subungueal dots in patients with chronic radiodermatitis, and posttraumatic haemorrhage under circumscribed hyperkeratosis (2). We have not found any descriptions of punctate disseminated lesions on the feet as seen in our patient.

The pathogenesis of previously mentioned lesions has been considered to be traumatic, although other causes are possible, as described for subungueal splinter haematomas (such as infectious endocarditis, antiphospholipid antibody syndrome, or arterial catheterization). After a haemorrhage in the papillary dermis, blood is eliminated transepidermally, through the least resistant periductal areas (2). The fact that our patient could not walk might be a predisposing factor for his lesions, as the skin of his feet might be thinner than usual. These characteristics lesions could be mistaken for purpura associated with severe illness. The simple method of trimming the surface of the lesions can make the diagnosis clear and might avoid unnecessary work-up for the patient.

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