Table II. Prison malpractice cases won by plaintiff (N = 3)

Year	Sex	Location	Payout, USD	Reason for lawsuit	Setting	Site
1990	Male	Northeast	$989,034.54	Misdiagnosis of fungal infection as ichthyosis, leading to eventual amputation	Prison	Foot
2008	Male	Northeast	$2,384,136.45	Did not biopsy, leading to metastasis of cutaneous melanoma	Veterans Affairs	Nose
2013	Female	South	$766,042.21	Improper procedures followed for radiation, leading to radiodermatitis	Nonacademic Hospital	Head

Payout is adjusted for inflation to July 2018. The rationale for the decision for all cases won by the plaintiff was negligence.

unclear cases. Limitations of this study include the inability to evaluate cases settled outside of court and variation in the level of detail provided by proceedings of different jurisdictions. Close collaboration of dermatologists with prison medical staff might minimize malpractice risk for incarcerated patients and providers, lead to greater access to dermatologists, and ultimately improve clinical outcomes.

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REFERENCES

1. Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. *N Engl J Med*. 2011;365(7):629-636.
2. Kornmehl H, Singh S, Adler BL, Wolf AE, Bochner DA, Armstrong AW. Characteristics of medical liability claims against dermatologists from 1991 through 2015. *JAMA Dermatol*. 2018;154(2):160.
3. Glaze LE, Kaeble D. Correctional populations in the United States, 2013. https://www.bjs.gov/content/pub/pdf/cpus13.pdf; 2014. Accessed August 17 2018.
4. Coury C, Kelly B. Prison dermatology. *J Correct Health Care*. 2012;18(4):302-308.
5. Medical Malpractice. LexisNexis Academic Legal Database. http://www.lexisnexis.com/documents/academic/academic_migration/LexisNexisAcademicUserGuide-1.pdf; 2018.
6. Bureau of Labor Statistics. Consumer price index inflation calculator. Databases, tables, and calculators by subject. https://www.bls.gov/data/inflation_calculator.htm.

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Pressure alopecia in pediatric and adult patients: Clinical and trichoscopic findings in 12 cases

To the Editor: Pressure alopecia (PA) is an infrequent form of hair loss due to ischemic changes to the scalp. It affects adults and children as a complication of prolonged head immobilization during surgery or hospitalization.[1,2] PA occurs as a localized alopecic area, usually overlying scalp prominences. It is generally transient. We reviewed the records of patients with PA who were seen for dermatologic consultation in our hospital during the period from 2010 to 2017. We present what to our knowledge is the largest series in the literature investigating trichoscopy of PA (N = 12) (Table I).

On clinical examination, the early acute phase of PA shows erythema and sometimes ulceration. Skin necrosis, loss of adnexal structures, and cicatricial outcome may occur, depending on the severity and duration of pressure or operative time and on patients' characteristics. The diagnosis can be challenging when a transient decrease of papillary blood supply to the hair bulb induces anagen effluvium[3] but the skin integrity is maintained. The clinical history and location of alopecia shed light on the diagnosis in mild cases.

In our series, hospitalization and head immobilization were not the only causes of PA because subcutaneous masses and trauma shared the same hypoxic pathogenesis, similarly to pressure ulcers. In addition to the scalp (vertex and occipital region), the beard was a possible location of PA.

On trichoscopy, our patients with PA presented with dystrophic hairs and yellow and black dots

Table I. Clinical and trichoscopic data of patients affected by PA

Indicator	Details
Inclusion criteria	- History of hypoxic scalp injury (surgery with head immobilization or extended bed rest, trauma, or subcutaneous masses) - Circumscribed hair loss occurring within 30 d - Follow-up >6 mo.
Exclusion criteria	- Previous or concomitant history of hair loss - Dermoscopic images not available
Sex	7 M (58.3%)/5 F (41.7%)
Age	27.4 y, range 1 mo to 69 y (6 children aged <18 y and 6 adults aged ≥18 years)
Location	- Vertex of the scalp (7 patients [58.3%]) - Occipital region of the scalp (4 patients [33.3%]) - Beard area (1 patient [8.3%])
Cause	- Postoperative/coma blisters due to extended immobilization (eg, liver transplantation, surgery for Fallot tetralogy) (8 patients [66.7%]) - Lipoma (scalp)/inflamed epidermoid cyst (beard) (2 patients [16.7%]) - Mechanical treatment (2 patients [16.7%]) (surgical intervention for scalp fracture with insertion of a metal plaque [1 patient], helmet wearing for hypothermic therapy in ischemic perinatal encephalopathy [1 patient])
Trichoscopy	- Dystrophic hairs (11 patients [91.7%]) - Fragmented hairs (9 patients [75.0%]) - Yellow dots (8 patients [66.7%]) - Black dots (4 patients [33.3%]) - Presence of follicles (10 patients [83.3%])/absence of follicles (1 patient [8.3%) - Dilated vessels (2 patients [16.7%]) - Ulcer (1 patient [8.3%])
Treatment	- High-potency topical corticosteroids (clobetasol propionate 0.05% foam or cream under occlusion) (100%)
Outcome	- Permanent (1 patient [8.3%]) - Healed (11 patients [91.7%]) (after a mean of 3 mo)
Mean follow-up	24.3 mo

F, Female; *M,* male; *PA,* pressure alopecia.

Fig 1. Pressure alopecia on the vertex of the scalp after extended immobilization in a 5-year-old girl. **A,** Clinical appearance: circumscribed erythematous nonulcerated alopecic area, 3.5 cm in diameter. **B,** Trichoscopy findings: yellow dots, dystrophic hairs, black dots. **C,** Clinical appearance after 1 month of topical corticosteroid treatment: gradual hair regrowth. **D,** trichoscopy findings: diffuse circle hairs. (Original magnifications: **B** and **D**, ×20.)

during the early phase (Fig 1). Besides removal of the causes of hypoxia, therapy with high-potency topical corticosteroids was used.

In all, 91.7% of the patients experienced complete healing after a mean period of 3 months. During the late phase of PA, after 1 month, the regrowth of hairs of the same length was clinically evident. Trichoscopy revealed yellow-brown crusts, dilated infundibula, and diffuse circle hairs. These hairs have a thin and regularly coiled short stem with a tapered end.

Only a 6-year-old girl with a large scalp ulcer after hypoxia during scalp surgery developed scarring alopecia, showing permanent adnexal damage and absence of follicular ostia (yellow dots on trichoscopy).

When trichoscopy is performed on PA, other hair loss conditions, such as alopecia areata (AA), should be differentiated.[3,4] Black dots indicate acute transient damage to anagen hair follicles, being typical but not specific of AA.[5] On the other hand, exclamation point hairs are exclusive to AA. Dystrophic hairs and black dots are also common in tinea capitis, but the absence of comma hairs, Morse code–like hairs and hair casts, scaling, and inflammation suggests a PA diagnosis. Trichotillomania may present with black dots and dystrophic hairs, but in addition it shows hairs of different lengths and flame hairs on trichoscopy. The patient's history usually orients the diagnosis. Circle hairs are common in the regrowing phases of various alopecic conditions, including chemotherapy-induced alopecia and AA.[5]

In conclusion, PA is reversible if promptly recognized. Preventive measures are recommended in hospitalized and surgical patients. The patient's history and trichoscopy may help with the diagnosis. We suggest considering circle hairs as a favorable prognostic finding of reversible PA. The histopathologic features of PA and the role of topical corticosteroids should be further investigated.

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REFERENCES

1. Chang ZY, Ngian J, Chong C, Chong CT, Liew QY. Postoperative permanent pressure alopecia. *J Anesth*. 2016; 30:349-351.
2. Khokhar RS, Baaj J, Alhazmi HH, Dammas FA, Aldalati AM. Pressure-induced alopecia in pediatric patients following prolonged urological surgeries: the case reports and a review of literature. *Anesth Essays Res*. 2015;9(3):430-432.
3. Sano DT, Kakizaki P, Anzai A, Donati A, Valente NYS, Romiti R. Headband pressure alopecia: clinical, dermoscopy, and histopathology findings in four patients. *Int J Dermatol*. 2018;57(2):237-239.
4. Loh SH, Lew BL, Sim WY. Pressure alopecia: clinical findings and prognosis. *J Am Acad Dermatol*. 2015;72(1):188-189.
5. Kowalska-Oledzka E, Slowinska M, Rakowska A, et al. 'Black dots' seen under trichoscopy are not specific for alopecia areata. *Clin Exp Dermatol*. 2012;37:615-619.

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Chronic nonscarring scalp folliculitis: Retrospective case series study of 34 cases

To the Editor: Scalp folliculitis (SF) has different presentations with varying intensity: chronic nonscarring SF (CNSSF), folliculitis decalvans, tufted folliculitis, acne keloidalis nuchae, and dissecting cellulitis. Few articles describe the clinical features and therapeutic management of CNSSF.

We conducted a retrospective study searching for CNSSF and reviewed hospital records from January 2016 to December 2017 at our institution. Patients with clinical features of other forms of scarring folliculitis were excluded. We recorded sex, age, disease duration, lesion location, culture results, biopsy findings, therapies, and follow-up data until May 2018.

We retrieved data on 34 men aged 22 to 49 years (mean, 34.9 years). Disease onset was between 2 months and 30 years before diagnosis (mean 59 months). The locations of the papules and pustules were as follows: 80% occipital, 35% vertex, 26% temporal, and 20% parietal, as lesion spread could affect several areas in the same patient. In all, 17 patients (50%) had skin pustule cultured. Saprophyte flora (a mix of *Staphylococcus spp* [excluding *S aureus*], *Propionibacterium spp,* and *Micrococcus spp* without predominance of any of them) grew in 12 of the 17 cultures (70.5%), *S aureus* grew in 1 culture (6%), *Staphylococcus epidermidis* grew