involvement is rare in children, and in line with recommendations (1), we elected not to perform a bone marrow examination given the patient’s normal complete blood count and normal annual abdominal ultrasounds.

Mast cell–derived inflammatory mediators include leukotrienes, and the leukotriene CysLT1 receptor has been found on the surface of mast cells. Urinary leukotriene E4 can be measured as a marker of leukotriene-mediated inflammation, and its excretion is high in individuals with systemic mastocytosis (2). Montelukast, a competitive inhibitor of the leukotriene CysLT1 receptor, has been used to treat urinary symptoms in adults with isolated interstitial cystitis and detrusor mastocytosis (3). There are only two reports of its use in systemic mastocytosis, with treatment with montelukast resulting in a reduction in respiratory and possibly cutaneous symptoms but no mention of an effect on abdominal or urinary symptoms (4,5). Although the action of montelukast is mediated through inhibition of leukotriene receptors on target tissues, a further mechanism may involve inhibition of leukotriene-mediated autocrine mast cell degranulation, as has been reported in vivo (6). Montelukast has the additional benefit of better oral absorption than sodium cromoglycate (1), which may account for the improvement in symptoms beyond what had previously been achieved with cromoglycate.

In conclusion, leukotriene antagonists may be a useful adjuvant in people with systemic mastocytosis, particularly those with refractory gastrointestinal and urinary symptoms, and may permit a reduction in concurrent pharmacotherapy.

REFERENCES
potassium hydroxide and fungal cultures with Sabouraud CAF incubated for 4 weeks at 27°C.

All patients were examined using a handheld dermoscope, and photographs were taken directly through it using a digital camera. In all cases, mycologic examination revealed mycelial elements under light microscopy, and the culture grew *T. violaceum*.

The first patient was a 7-year-old Egyptian boy residing in Italy for 5 years, the second was a 3-year-old Ethiopian boy residing in Italy for 1 year (Fig. 1), and the third was an adopted 6-year-old Congolese girl residing in Italy for 1 month. Clinically they had “black dot” TC with multiple alopecic patches without desquamation.

Dermatoscopic observations of all these cases revealed numerous comma-shaped hairs and some dystrophic hairs (Fig. 2). No corkscrew hairs were detected.

These findings are in accordance with Slowinska’s first description (2). Recently Hughes described corkscrew hairs and speculated that they may be associated with TC in black people or with *T. soudanense* infection (3). Because all of the patients observed in our study were black, corkscrew hairs may be a characteristic dermatoscopic pattern of *T. soudanense* TC and not a characteristic of black people.

In conclusion, we believe that dermatoscopy may be a useful, rapid method for the diagnosis of TC, especially in cases with atypical presentation or with mild clinical features. Further study may be needed to confirm these findings.

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**WELLS’ SYNDROME PRESENTING AS A NONINFECTIOUS BULLOUS CELLULITIS IN A CHILD**

**Abstract:** Wells’ syndrome is a rare disease that is even more uncommon in childhood. This case report illustrates the potential devastating extent of the disease and highlights the unusual presentation of bullae in a child. It is imperative to consider Wells’ syndrome in patients with presumed cellulitis and eosinophilia who fail to respond to antibiotics.

**BRIEF REPORT**

An 11-year-old previously healthy African American woman was referred for consultation regarding the