Everything is in the name: Macular hyperpigmentation of uncertain etiology or acquired dermal macular hyperpigmentation of varied etiologies?

Sir,

He, who steals my purse, steals trash, but he that filches from me my good name robs me of that which enriches him not, and makes me poor indeed – William Shakespeare

We read with interest the letter by Gupta and Sharma on the controversies surrounding the nomenclature of ashy dermatosis, erythema dyschromicum perstans, lichen planus pigmentosus and pigmented cosmetic dermatitis.[1] The interest in cutaneous disorders characterized by brownish-slate gray-purplish black hyperpigmentation on face, neck, flexures and trunk, associated with interface dermatitis and pigment incontinence, and a virtually nonexistent prior clinical inflammatory phase is increasing. Though described as early in 1959 as los cenicientos by Ramirez, followed by ashy dermatosis,[2] lichen planus pigmentosus,[3] pigmented contact dermatitis and pigmented cosmetic dermatitis[4] in 1970s, these disorders were considered enigmatic and there were only a few published studies till recently, when the interest in these entities has renewed and multiple studies have been published in this regard, the important ones being dermatoscopic evaluation,[5] role of patch testing[6] and providing a novel scoring system.[7] Our center has been actively involved in describing the epidemiology, clinical features, risk factors, disease associations, dermatoscopy and treatment of these disorders.[8-11] In this context, we would like to convey our viewpoint on the controversies surrounding the nosology of these overlapping dermatoses.

In general, name introduces the readers and researchers to an entity, and should convey the important and salient defining features of a dermatosis. It can raise the interest or kill the spirit. In 2016, Chandran and Kumarasinghe had first proposed the term "acquired macular (hyper) pigmentation of uncertain etiology" for a group of disorders characterized by "acquired macular hyperpigmentation" with small and large macules associated with evidence of current or resolved interface dermatitis with pigment incontinence histopathologically, without any clinically evident prior inflammatory skin lesions.[12] Gupta and Sharma have reiterated

the same terminology as "macular hyperpigmentation of uncertain etiology," but omitted the term "acquired." Given the clinicopathological and dermatoscopic overlap amongst these disorders, we support their view of bringing these disorders under one roof and our opinion has been firmly echoed in our previous studies.[5,7,9,13]

But, we differ on the choice of nomenclature for the umbrella term and prefer the name "acquired dermal macular hyperpigmentation of varied etiologies" to "macular hyperpigmentation of uncertain etiology." The clinical differentials of macular hyperpigmentation are multiple and include fixed drug eruptions, melasma, ochronosis, macular amyloidosis, drug-induced and post inflammatory hyperpigmentation, nevus of Ota and other dermal melanocytoses, many of which have uncertain etiology. The name "macular hyperpigmentation of uncertain etiology," therefore, could misguide the readers about all possible dermatoses that could be encompassed in this term.

To the contrary, the term acquired dermal macular hyperpigmentation of varied etiologies divulges details about the origins and natural history (acquired), localization (dermal) and character (macular) of the hyperpigmentation, and therefore, is more informative and does justice to the scientific literature described so far in the context of these disorders without increasing more paradigms, besides signifying their treatment-resistant nature that stems from localization of pigment inside dermis. Many triggering factors and associations have been described in the etiopathogenesis of lichen planus pigmentosus, ashy dermatosis and pigmented contact/cosmetic dermatitis including genetic predisposition to lichen planus, type 4 hypersensitivity reaction to amla oil and mustard oil, trauma, friction, hepatitis C infection, influence of sex hormones and contact allergens such as *para*-phenylenediamine.[14] A recent study by Sharma *et al.* reported patch test positivity in 17/50 (34%) patients diagnosed as "lichen planus pigmentosus" and the authors opined that there is a "probable role of allergens in causing lichen planus pigmentosus on the face."[6] Thus, the words "varied etiologies" provide more rationale to the etiopathogenesis of these disorders than "uncertain etiology."

With multiple studies in tow, the future of these enigmatic disorders seems hopeful and we could start contributing to it by devising and following a uniform nomenclature, which could be improved further as more research unfolds. A consistent terminology shall maintain constancy in the reporting of clinical trials and facilitate communication among researchers. Although moving forward and embracing new terminologies comes along with continued research, one should, nevertheless, remember the significant and unrelenting contribution of Ramirez, Bhutani and Nakayama to "acquired dermal macular hyperpigmentation," in particular, regarding the initial events in the intricate pathogenesis of these complex disorders. Because the end result in the form of dermal hyperpigmentation is similar in all of these, remembering the semantics shall guide further research in the initiating and perhaps, the most important events in the natural history of these disorders, where novel therapeutics and preventive measures could act.

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