TABLE 72-11 CAUSES OF HYPERPIGMENTATION

- I. Primary cutaneous disorders
  - A. Localized
    - 1. Epidermal alteration
      - a. Seborrheic keratosis
      - b. Pigmented actinic keratosis
    - 2. Proliferation of melanocytes
      - a. Lentigo
      - b. Melanocytic nevus (mole)
      - c. Melanoma
    - 3. Increased pigment production
      - a. Ephelide (freckle)
      - b. Café au lait macule
      - c. Postinflammatory hyperpigmentation
  - B. Localized and diffuse
    - 1. Drugs (e.g., minocycline, hydroxychloroquine, bleomycin)
- II. Systemic diseases
  - A. Localized
    - 1. Epidermal alteration
      - a. Seborrheic keratoses (sign of Leser-Trélat)
      - b. Acanthosis nigricans (insulin resistance, other endocrine disorders, paraneoplastic)
    - 2. Proliferation of melanocytes
      - a. Lentigines (Peutz-Jeghers and LEOPARD syndromes; xeroderma pigmentosum)
      - b. Melanocytic nevi (Carney complex [LAMB and NAME syndromes])[a]
    - 3. Increased pigment production
      - a. Café au lait macules (neurofibromatosis, McCune-Albright syndrome[b])
      - b. Urticaria pigmentosa[c]
    - 4. Dermal pigmentation
      - a. Incontinentia pigmenti (stage III)
      - b. Dyskeratosis congenita
  - B. Diffuse
    - 1. Endocrinopathies
      - a. Addison's disease
      - b. Nelson syndrome
      - c. Ectopic ACTH syndrome
      - d. Hyperthyroidism
    - 2. Metabolic
      - a. Porphyria cutanea tarda
      - b. Hemochromatosis
      - c. Vitamin B_{12}, folate deficiency
      - d. Pellagra
      - e. Malabsorption, including Whipple's disease
    - 3. Melanosis secondary to metastatic melanoma
    - 4. Autoimmune
      - a. Biliary cirrhosis
      - b. Systemic sclerosis (scleroderma)
      - c. POEMS syndrome
      - d Eosinophilia-myalgia syndrome[d]
    - 5. Drugs and metals (e.g., arsenic)

[a]Also lentigines. [b]Polyostotic fibrous dysplasia. [c]See also "Papulonodular Skin Lesions." [d]Late 1980s.

Abbreviations: LAMB, *l*entigines, *a*trial *m*yxomas, *m*ucocutaneous myxomas, and *b*lue nevi; LEOPARD, *l*entigines, *E*CG abnormalities, *o*cular hypertelorism, *p*ulmonary stenosis and subaortic valvular stenosis, *a*bnormal genitalia, *r*etardation of growth, and *d*eafness (sensorineural); NAME, *n*evi, *a*trial myxoma, *m*yxoid neurofibroma, and *e*phelides (freckles); POEMS, *p*olyneuropathy, *o*rganomegaly, *e*ndocrinopathies, *M*-protein, and *s*kin changes.

hyperpigmentation is seen on the neck, trunk, and thighs and is accompanied by nail dystrophy, pancytopenia, and leukoplakia of the oral and anal mucosae. The latter often develops into squamous cell carcinoma. In addition to the flagellate pigmentation (linear streaks) on the trunk, patients receiving bleomycin often have hyperpigmentation overlying the elbows, knees, and small joints of the hand.

Localized hyperpigmentation is seen as a side effect of several other *systemic medications*, including those that produce fixed drug reactions (nonsteroidal anti-inflammatory drugs [NSAIDs], sulfonamides, barbiturates, and tetracyclines) and those that can complex with melanin (antimalarials) or iron (minocycline). Fixed drug eruptions recur in the exact same location as circular areas of erythema that can become bullous and then resolve as brown macules. The eruption usually appears within hours of administration of the offending agent, and common locations include the genitalia, distal extremities, and perioral region. Chloroquine and hydroxychloroquine produce gray-brown to blue-black discoloration of the shins, hard palate, and face, while blue macules (often misdiagnosed as bruises) can be seen on the lower extremities and in sites of inflammation with prolonged minocycline administration. Estrogen in oral contraceptives can induce melasma—symmetric brown patches on the face, especially the cheeks, upper lip, and forehead. Similar changes are seen in pregnancy and in patients receiving phenytoin.

In the diffuse forms of hyperpigmentation, the darkening of the skin may be of equal intensity over the entire body or may be accentuated in sun-exposed areas. The causes of diffuse hyperpigmentation can be divided into four major groups—endocrine, metabolic, autoimmune, and drugs. The endocrinopathies that frequently have associated hyperpigmentation include *Addison's disease*, *Nelson syndrome*, and *ectopic ACTH syndrome*. In these diseases, the increased pigmentation is diffuse but is accentuated in sun-exposed areas, the palmar creases, sites of friction, and scars. An overproduction of the pituitary hormones α-MSH (melanocyte-stimulating hormone) and ACTH can lead to an increase in melanocyte activity. These peptides are products of the proopiomelanocortin gene and exhibit homology; e.g., α-MSH and ACTH share 13 amino acids. A minority of patients with Cushing's disease or hyperthyroidism have generalized hyperpigmentation.

The metabolic causes of hyperpigmentation include *porphyria cutanea tarda* (PCT), *hemochromatosis*, *vitamin B_{12} deficiency*, *folic acid deficiency*, *pellagra*, and *malabsorption*, including *Whipple's disease*. In patients with PCT (see "Vesicles/Bullae," below), the skin darkening is seen in sun-exposed areas and is a reflection of the photoreactive properties of porphyrins. The increased level of iron in the skin of patients with type 1 hemochromatosis stimulates melanin pigment production and leads to the classic bronze color. Patients with pellagra have a brown discoloration of the skin, especially in sun-exposed areas, as a result of nicotinic acid (niacin) deficiency. In the areas of increased pigmentation, there is a thin, varnish-like scale. These changes are also seen in patients who are vitamin B_6 deficient, have functioning carcinoid tumors (increased consumption of niacin), or take isoniazid. Approximately 50% of the patients with Whipple's disease have an associated generalized hyperpigmentation in association with diarrhea, weight loss, arthritis, and lymphadenopathy. A diffuse, slate-blue to gray-brown color is seen in patients with *melanosis secondary to metastatic melanoma*. The color reflects widespread deposition of melanin within the dermis as a result of the high concentration of circulating melanin precursors.

Of the autoimmune diseases associated with diffuse hyperpigmentation, *biliary cirrhosis* and *systemic sclerosis* are the most common, and occasionally, both disorders are seen in the same patient. The skin is dark brown in color, especially in sun-exposed areas. In biliary cirrhosis, the hyperpigmentation is accompanied by pruritus, jaundice, and xanthomas, whereas in systemic sclerosis, it is accompanied by sclerosis of the extremities, face, and, less commonly, the trunk. Additional clues to the diagnosis of systemic sclerosis are mat and periungual telangiectasias, calcinosis cutis, Raynaud's phenomenon, and distal ulcerations (see "Telangiectasias," above). The differential diagnosis of cutaneous sclerosis with hyperpigmentation includes