Congenital satellite nevi are known risk factors for neurocutaneous melanosis.\textsuperscript{1} Their impact on the risk for malignant melanoma is not as well established, but some studies point to a possible increased risk in patients with GCMN and satellite nevi.\textsuperscript{1,3} In summary, our patient is an example of the need for continued dermatologic follow-up and high index of suspicion for new nodules appearing in patients with a history of GCMN.

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Perineal Groove: A Report of 2 Cases

A perineal groove is a rare and usually uncomplicated congenital malformation of the perineum characterized by a wet suls that extends from the posterior fourchette to the anus. Of 12 previously described cases, only 1 has been reported in the dermatology literature.\textsuperscript{1-6}

Report of Cases | Case 1. A 4-month-old term white girl was referred to pediatric dermatology by her pediatrician and a pediatric surgeon for evaluation of a congenital perineal lesion. The mother’s pregnancy was unremarkable, and the infant was healthy. The lesion had been stable and uncomplicated since birth. Barrier creams were attempted for presumed diaper dermatitis without response. Physical examination showed a well-demarcated, erythematous, superficial ulcer anterior to the anus (Figure, A). A fungal culture was negative. At the 1-month
A perineal groove is a rare congenital anomaly that occurs mostly in female patients, with only 1 reported case in a male patient. While the exact pathogenesis remains unclear, a perineal groove may result from faulty development of the embryonic cloaca, the perineal raphe’s failure to fuse, or a defect in the development of the uroanal septum. A perineal groove may persist or resolve spontaneously as the potential for self-healing has passed. While the lesion remained asymptomatic and stable at last follow-up, the ulcer remained unchanged. The infant underwent treatment with pulsed-dye laser for the possible diagnosis of ulcerated hemangioma, which led to improvement in the erythema. Six months later, when the ulceration remained largely unchanged, a skin biopsy was performed. Histologic specimens showed hyperkeratosis, hypergranulation, fibrosis, and vascular dilatation. Abdominal and pelvic ultrasonography was performed to rule out associated anomalies, and the findings were normal. A diagnosis of perineal groove was ultimately made clinically without further intervention. The lesion remained asymptomatic and stable at last follow-up, patient age, 16 months.

Case 2. A 6-month-old and otherwise healthy white girl was sent to pediatric dermatology clinic by her pediatrician for evaluation of a stable, asymptomatic perineal lesion noted at age 2 months. The mother had an unremarkable pregnancy history except for diet-controlled gestational diabetes. The infant had been treated with multiple barrier and antifungal creams without improvement. Physical examination showed a well-demarcated, erythematous ulcer anterior to the anus (Figure, B). Cultures for bacteria and fungus were negative. The diagnosis of perineal groove was made clinically. A skin biopsy and imaging were offered, but the parents declined. At age 14 months, the lesion was less pronounced and remained asymptomatic.

Discussion | A perineal groove is a rare congenital anomaly that occurs mostly in female patients, with only 1 reported case in a male patient. While the exact pathogenesis remains unclear, a perineal groove may result from faulty development of the embryonic cloaca, the perineal raphe’s failure to fuse, or a defect in the development of the uroanal septum.

A perineal groove may initially be confused with an ulcerated hemangioma, irritant dermatitis, infection, lichen sclerosis, perianal pyramidal protrusion, trauma, or sexual abuse, often rendering the diagnosis difficult. The diagnosis is made clinically, with biopsy rarely performed. While histologic findings vary, nonkeratinizing squamous epithelium with an intervening area of rectal type or transitional epithelium has been reported from excision specimens.

Imaging for associated regional anomalies may be considered, although such anomalies are believed to be rare. In the literature, there is 1 case of a perineal groove associated with hypospadias and a bifid scrotum, 1 with an ectopic anus, and another with an associated urinary tract anomaly.

A perineal groove may persist or resolve spontaneously within a year of presentation. While most lesions remain asymptomatic, rare complications of constipation, urinary tract infections, and skin infections have been reported. Treatment is generally not needed unless lesions cause recurrent problems such as infections or mucous drainage. Surgery may also be considered for cosmetic reasons. If surgical treatment is pursued, it is recommended only after the age of 2 years, when the potential for self-healing has passed.

We report 2 cases of perineal groove to increase awareness of this unusual malformation. Understanding that a perineal groove as a minor perineal anomaly will help avoid misdiagnosis and prevent extensive evaluations or unnecessary surgical procedures.

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CORRECTION

Incorrect Financial Disclosure: In the Original Investigation titled “Undertreatment, Treatment Trends, and Treatment Dissatisfaction Among Patients With Psoriasis and Psoriatic Arthritis in the United States: Findings From the National Psoriasis Foundation Surveys, 2003-2011” published online August 14, 2013, and also in the October print issue of JAMA Dermatology (2013;149[10]:1180-1185. doi:10.1001/jamadermatol.2013.5264), incorrect information appeared in the Conflict of Interests Disclosures section of the Article Information on page 1185. That section should have appeared as follows: “Dr Armstrong has received research grants or consultant honoraria from Abbott Laboratories, Amgen, Inc, and Janssen Biotech. Dr Lebwohl has been a consultant and/or investigator for Abbott Laboratories, Amgen, Inc, Anacor Pharmaceuticals, Inc, BioLine RX, Ltd, Celgene Corporation, Columbia Laboratories, Inc, Coronado Biosciences, Dermipir, Ltd, Eli Lilly & Co, Galderma, GlaxoSmithKline-Stiefel, Janssen Ortho Biotech, LEO Pharmaceuticals, Manuho Co, Ltd, Meda Pharmaceuticals, Novartis, Pfizer, Ranbaxy Laboratories, Ltd, Thesan Pharmaceuticals, and Valeant Pharmaceuticals. The other authors reported no disclosures.” This article was corrected online.

Incorrect Information in Abstract: In the Case Report/Case Series titled “Facial Allergic Granulomatous Reaction and Systemic Hypersensitivity Associated With Microneedle Therapy for Skin Rejuvenation” published online November 20, 2013, in JAMA Dermatology (doi:10.1001/jamadermatol.2013.6955), incorrect information appeared in the Abstract on page E1. The first sentence of the Observations section should have read: “We describe 3 women, aged 40s to 60s, who developed facial granulomas following microneedle therapy for skin rejuvenation.” This article was corrected online and in print.

NOTABLE NOTES

Male Circumcision as a Religious Ritual
Barry Ladizinski, MD; Erik Rukhman, BS; Kachiu C. Lee, MD, MPH

Circumcision (from the Latin circumcicere, meaning “to cut around”) is the surgical removal of the penile foreskin or prepuce. Although the exact origin of this procedure is unknown, the earliest record of the practice comes from an Egyptian wall painting dating back to 2352 BC. Today, approximately one-third of the world’s male population is circumcised. Circumcision is most prevalent in the Middle East, United States, and parts of Africa and Southeast Asia, where it is predominantly performed as a religious ritual among followers of Judaism, Islam, Coptic Christianity, and the Ethiopian Orthodox Church.1,2

In Judaism, the covenant of circumcision (brit milah) is performed by a mohel (circumciser) on the eighth day of life, representing an external sign of the covenant between God and the Jewish people.1 In Genesis 17:12-14, God instructs Abraham: “For the generations to come every male among you who is eight days old must be circumcised... Any uncircumcised male, who has not been circumcised in the flesh, will be cut off from his people; he has broken my covenant.”3 Some ultra-Orthodox Jewish sects practice metzitzah b’peh, in which the mohel places his mouth on the infant’s penis following circumcision to suck blood from the wound.3,4 This practice has been associated with multiple cases of neonatal herpes simplex virus (HSV), and most Jewish ritual circumcisions today are performed with an oral suction device.3,4

In Islam, circumcision (khitan) can be performed from birth until puberty to signify purification (tahera) and an eternal relationship with God. While the tradition was not specifically mentioned in the Qur’an, the Prophet Muhammad recommended it for hygienic purposes, and today it is a virtually universal Islamic practice. Muslim men must also be circumcised to complete the pilgrimage (hajj) to Mecca, 1 of the 5 pillars of Islam. Although Jesus Christ, born into the Jewish religion, was circumcised on his eighth day of life, the New Testament does not require the practice.1

Circumcision may also be performed for medical reasons, such as phimosis or chronic balanitis. Circumcision is associated with reduced incidence of urinary tract infections, sexually transmitted infections (eg, human immunodeficiency virus [HIV], HSV, and human papillomavirus), phimosis, paraphimosis, balanitis, posthitis, and penile cancer.1,2 The World Health Organization and Joint United Nations Programme on HIV/AIDS recommend circumcision as a health intervention to aid prevention of HIV transmission in endemic areas.1,2 Complications are uncommon, occurring in less than 1% of cases. The most common complications are bleeding, infection, redundant prepuce, and inadequate skin removal.2 Circumcision does not negatively affect sexual function, sensitivity, or satisfaction.2

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