suggestive and is characterized by an erythematous border encompassing the orange-yellow lesion.[4] Although rare, JXG may be associated with potentially serious extracutaneous manifestations, particularly in patients with multiple skin lesions.[3] The most common extracutaneous site involved is the iris, especially in young children, with possible complications including intraocular hemorrhage, glaucoma, and loss of vision.[3] Mortality is rare, but can occur owing to liver failure or central nervous system disease in patients with multiple extracutaneous lesions.[5] Additionally, JXG has been associated with the development of juvenile chronic myelogenous leukemia, particularly in patients with concomitant neurofibromatosis type 1.[6]

Most cutaneous lesions spontaneously regress; therefore, therapy is not usually required, although surgical removal can be pursued for cosmetic reasons.[2] Ophthalmic examination is recommended for patients under 2 years old with multiple, small (<10 mm) lesions.[7] In conclusion, although an uncommon entity, clinicians should consider JXG in young children presenting with single or multiple pink-red or yellow-brown papules or nodules, especially those with a setting-sun pattern on dermoscopy. ■

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Milia-Like Idiopathic Calcinosis Cutis: When Waiting Is the Best Option

A 6-month-old boy was referred to our department for the presence of diffuse multiple whitish, pseudomilia-like papules on the skin of the extremities since birth. The patient was well-appearing and afebrile, with normal vital signs. The examination revealed multiple, yellow-white, firm, small, subcutaneous nodules and papules (**Figure 1**, A-C). The lesions were present only on the extremities, arms, and legs. The lesions were in different stages, with a precise evolution process toward extrusion of a whitish material, erosion, and healing (**Figure 1**, A). This clinical presentation was consistent with a diagnosis of calicinosis cutis. To confirm our diagnosis, we performed an incisional biopsy. Histopathologic examination showed the accumulation of well-defined, dense, basophilic material surrounded by fibrous tissue in the dermis (**Figure 2**, A, B). Biochemical studies, including serum calcium, phosphate, parathyroid hormone, vitamin D, and organic acid levels were within the normal range, distinguishing idiopathic calcinosis cutis from metastatic, dystrophic, and iatrogenic calcinosis. Based on pathologic and clinical findings, the patient was diagnosed with milia-like idiopathic calcinosis cutis (MICC).[1-3]

Characteristically, MICC lesions appear as multiple whitish to skin colored, firm, tiny milia-like papules, mostly on the hands and feet. Lesions may have an erythematous halo and may perforate, causing transepidermal calcium elimination. The differential diagnosis is with molluscum, warts, milia, or inclusion cysts. Although definitive confirmation of MICC is based on histopathologic diagnosis, dermoscopy may be helpful in the differential diagnosis. Since the first description in 1978, numerous reports confirmed a strong association between MICC and Down syndrome[2,3]; however, there are a small

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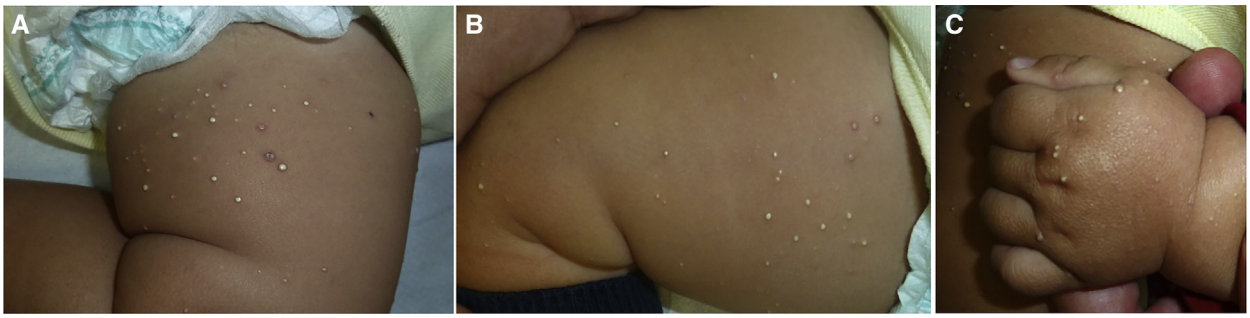

Figure 1. **A-C,** Multiple, yellow-white, firm, small, subcutaneous nodules and papules on the extremities, arms, and legs.

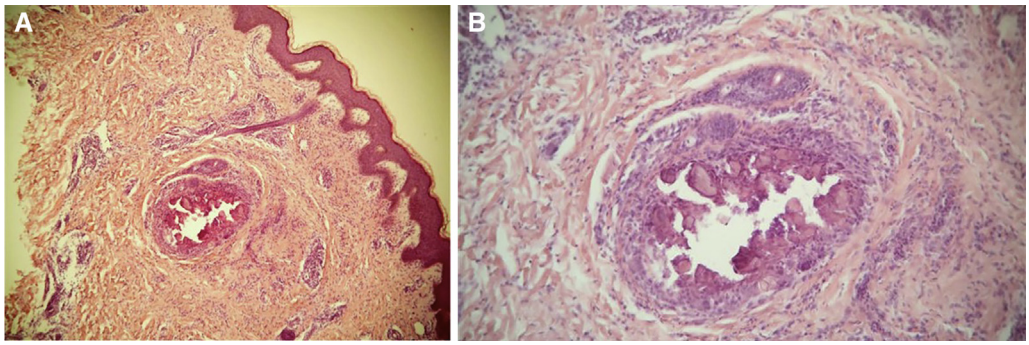

Figure 2. **A, B,** Histopathologic examination showing the accumulation of well-defined, dense, basophilic material surrounded by fibrous tissue in the dermis.

number of case reports of MICC in children without Down syndrome.[4] All cases of MICC reported had complete resolution of the lesions within years without surgical treatment; therefore, we decided to follow without intervention. The pathogenesis of MICC remains unknown. ■

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