financial means are more likely to present to dermatologists with larger cutaneous tumors.[2] Mohs micrographic surgery treatment delays and inaccessibility may impact disease progression and contribute to known disparities in skin cancer outcomes. The older population in counties without Mohs surgeons suggests potential access barriers among this higher risk population. This supplements existing research that older veteran populations have more restricted MMS access because of limited Veterans Affairs (VA) MMS services and difficulties with care coordination through the VA Choice Program.[3]

Although the high proportion of private insurance in counties with Mohs surgeons may enable access, it is notable that health maintenance organizations and most private insurers require prior authorizations and a higher out-of-pocket cost for MMS as compared with Medicare,[4] which could pose a burden to providers and patients and potentially delay care. The higher proportion of patients with Medicaid among counties with ≤1 Mohs surgeon per 100,000 population and among counties without Mohs surgeons is also concerning, given lower physician participation rates in Medicaid and on-average longer wait times for appointments. In addition, despite the higher proportion of non-Hispanic Whites in counties with Mohs surgeons, our analysis does *not* suggest a notable difference in non-Hispanic Black prevalence. However, given that non-Hispanic Black individuals are less likely to receive MMS,[5] this finding suggests there may be other factors beyond local availability (e.g., cost, transportation, referrals, or insurance) that limit representation of this group among MMS patients.

Limitations in this study include the sole assessment of Medicare data, excluding a small subset of Mohs surgeons who may not perform services for this population. In addition, our study does not relate the impact of the identified characteristics to clinical outcomes. Despite these shortcomings, this study better characterizes sociodemographic patterns in counties with and without Mohs surgeons and is important amid a rising incidence of skin cancer and likely an associated increase in the demand for MMS. Further research surrounding the impact of geographic variation on clinical outcomes is warranted to better inform initiatives to address the identified differences.

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Dermoscopic Differentiation of Pilomatricoma From Pilomatrical Carcinoma

The value of dermoscopy in differentiating between pilomatricoma from its malignant counterpart, pilomatrical carcinoma (PC), has not been defined yet. In this report, we present data suggesting that dermoscopy may improve their preoperative differentiation.

The mother of a 6-year-old girl initially noticed an erythematous macule on her daughter's left cheek. Over a 6-month period, it slowly evolved into a nodule (Figure 1A). On dermoscopy, white clods of various shapes and sizes, surrounded by blue homogenous areas were the striking features. Adjacent erythema and short linear vessels were also found (Figure 1B).

Histopathology (Figure 1C,D) revealed well-circumscribed irregular islands composed of basaloid and ghost cells, with central eosinophilic keratinous material without visible cell outlines. Focal areas of calcification were scattered throughout the tumor lobules, which were surrounded with a mixed inflammatory infiltrate including multinucleated giant cells.

Pilomatricoma (pilomatrixoma/Malherbe calcified epithelioma) is a benign adnexal tumor derived from immature hair matrix cells with tendency toward calcification.[1] As it could express rapid growth and appears with a wide variety of clinical presentations (bullous, anetodermic, or perforating),[1–3] the accuracy of preoperative diagnosis ranges from 0% to 55% in reported cases.[1]

Although nodular basal cell carcinoma (BCC) and adnexal tumors are listed as the major dermoscopic differential diagnoses, in the authors' opinion, only PC may pose a diagnostic pitfall, particularly in elderly patients. Unlike

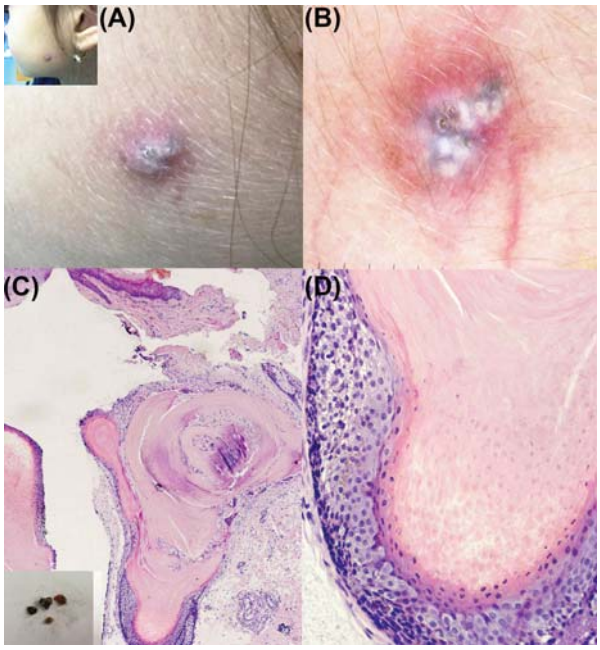

Figure 1. Pilomatricoma: (A) Clinical view showing an oval-shaped, bluish, hard, 7-mm nodule surrounded by erythema. (B) Dermatoscopy (contact, nonpolarized) shows central white clods mixed with small blue structureless areas, surrounded by erythema and a few, isolated, linear irregular telangiectasias. (C) Tumor lobules in the dermis, with empty spaces, probably corresponding to small stones that were expelled during a biopsy (inset). (D) Histopathology of well-circumscribed tumor islands, composed of basaloid and ghost cells, with central eosinophilic keratinous material (hematoxylin & eosin, magnification A-40×, B-200×).

benign pilomatricomas which have low recurrence rates (0%–3%)[1,3] after surgical excision, PCs are locally aggressive with a tendency toward recurrence after simple surgical excision (50%–60%) and metastasis.[4]

Whitish formations and streaks are assessed as equivalent to presence of calcification or cornified material and represent the striking feature in both pilomatricoma and PC.[5] Color of whitish formations may vary from completely white to yellow whitish, whereas variation in shape ranges from sharply demarcated blotches, as it was in our case, to diffuse homogeneous areas. However, distinctive differences in the borders can be observed, which are regular in pilomatricoma, whereas it is significantly jagged in PC.[5]

There is also a difference in the vascular pattern significant for the differentiation of these lesions. In our case, irregular linear vessels were found, whereas Zaballos and colleagues[1] reported more types of vessels in pilomatricomas. On the contrary, arborizing vessels found in PC have never been detected in pilomatricomas.[5] These vessels in PC are more subtle, more numerous, and out of focus compared with the branched arborizing vessels found in nodular BCC.

In pilomatricoma, melanin is rarely found (20%) and could be seen as blue clods or as homogenous areas, as it was in our case. Homogenous blue areas were also found in PC and do not represent a dermoscopic structure significant for distinguishing these 2 lesions. Although ulceration was not found in our case, this feature is not a rare finding in pilomatricomas (60%)[1] and, in authors' opinion, without greater significance in distinguishing pilomatricoma and PC.

In conclusion, in the absence of other distinctive dermoscopic features for any particular lesion, finding of irregular whitish formations in the hard, nodular lesion, may indicate both the pilomatricoma and PC. The findings of regular borders, as in our case, and different blood vessel types other than arborizing ones indicate a benign lesion. However, additional findings of jagged borders of whitish formations and subtle arborizing vessels are more supportive for PC.

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