Both the left (A) and right (B) earlobes demonstrate elongation and drooping that is noticeably more severe than that seen in normal aging. C, The patient is demonstrating her habit of pulling on her earlobe, which led to an exaggerated ptosis.

Exaggerated Earlobe Ptosis Due to Habitual Ear Pulling

A certain degree of earlobe drooping, known as earlobe ptosis, occurs with normal aging of the skin. We report the case of a woman with exaggerated earlobe ptosis due to habitually pulling the earlobes.

Report of a Case | A woman in her 90s presented with considerable drooping of the earlobes. On examination, the patient appeared well. The bilateral earlobes demonstrated thinning and elongation, also known as earlobe ptosis (Figure, A and B). After further questioning, she reported a habit of pulling at her earlobes. She stated that she initially pulled at them to relieve anxiety (Figure, C), but it eventually became a chronic behavior. After being advised that her behavior was likely the cause of her ptosis, she was able to discontinue it. She was not concerned cosmetically enough to accept corrective treatments when offered.

Discussion | Ptosis, or drooping of the earlobe, is defined as a lobe greater than 25% of the total ear length. The normal length of ear lobules, or the distance from the antitragus to the inferiormost edge of the auricle, has been found to vary from 1.5 to 2.0 cm in studies of both adults and children. The ear lobe, while it lacks cartilage, is composed of a large blood supply, many nerve endings, and adipose tissue. With normal aging, cumulative gravitational forces and the loss of tissue elasticity likely contribute to some amount of ptosis. This increase in total ear length with aging occurs due to lengthening of both the lobule and the cartilaginous parts of the ear. While a degree of our patient's earlobe ptosis may be attributed to the effects of aging, it was clearly exaggerated by her repetitive earlobe-pulling behavior. We considered proposing the eponym the Carol Burnett sign in homage to the comedian who would tug her left earlobe at the end of each episode of "The Carol Burnett Show."

Even though our patient declined intervention for her ptosis, treatment options exist and are typically used in patients undergoing a face-lift who continue to show signs of aging due to earlobe ptosis. Correction should be considered for aesthetic reasons when the lobule is greater than 33% of the total ear length or when the free margin of the lobule measures greater than 5 mm (ideal length is 1-5 mm). Treatment may be approached with either surgical correction of lobular height or rejuvenation with dermal filler, in particular hyaluronic acid products.

The earlobe ptosis in our patient was most likely attributable to normal aging with exacerbation due to her traumatic skin behaviors. Although she declined restorative treatment,
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this case demonstrates that correction could be considered for the appropriate patient.

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COMMENT & RESPONSE

Violaceous Necrotic Plaques on the Leg of an Immunosuppressed Patient

To the Editor In the JAMA Dermatology Clinicopathological Challenge that describes a man with cutaneous mucormycosis, Xu and colleagues1 state that the pathogen, Mucor species, is a member of the “Zygomyces class of the Mucorales order.” This phrasing inverts the usual taxonomic hierarchy, and to make things more confusing, the Zygomyces class no longer exists. Not that the “zygomycotic” organisms are extinct, but the taxonomic term Zygomyces is now obsolete. (The error of this phrase was recognized, and it was corrected online January 15, 2014; a printed correction was published in the March issue of JAMA Dermatology.2 We herein expand on that correction.)

Historically, fungal taxonomists have relied on morphology, particularly of reproductive structures, to classify related organisms into hierarchical groups.2 Recent advances in molecular phylogenetic analysis, however, indicate that the fungal phylum, Zygomycota (ie, the Zygomyces), is an artificial, polyphyletic entity.3 Stated simply, the fungi grouped molecular phylogenetic analysis, however, indicate that the fungi grouped into this now obsolete phylum resemble each other morphologically during some reproductive stages, but they are not descended from an immediate common ancestor. The 2 groups, Mucorales and Entomophthorales, which were previously considered subordinate members of the Zygomycota phylum, have now been elevated to the rank of subphyla (namely Mucoromycotina and Entomophthoromycotina).4

The pathogens classified within Entomophthoromycotina and those classified within Mucoromycotina differ in their molecular, genetic, ecologic, and epidemiologic characteristics.5 Of greater import to dermatologists, these groups usually differ in their clinicopathological effects.6 Dermatologists often struggle with fungal taxonomy because we, as physicians, are more concerned with clinical syndromes and pharmacologic therapies than with phylogenetic relationships. But knowing the relationships among pathogens is more than “mere stamp collecting”—it provides the basis to understand the epidemiology, pathophysiology, and treatment of diseases caused by these pathogens.

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CORRECTION

Transposed Data in Abstract, Table, and Text: In the Original Investigation titled “Autoimmune, Atopic, and Mental Health Comorbid Conditions Associated With Alopecia Areata in the United States” by Huang et al. published online May 22, 2013, and in the July issue of JAMA Dermatology (2013;149[7]:789-794. doi:10.1001/jamadermatol.2013.3049), 2 data values were inadvertently transposed in the Abstract, Table 2, and the text. On page 789, in the Results section of the Abstract, the percentages for inflammatory bowel disease should have appeared as 2.0% (line 2) and for psoriasis and psoriatic arthritis as 6.3% (line 4). On page 791, in Table 2, the numbers (percentages) in the AA group for inflammatory bowel disease should have been given as 42 (2.0%) and for psoriasis and psoriatic arthritis as 133 (6.3%). On the same page, in the Results section, second paragraph, the percentages for inflammatory bowel disease should have appeared as 2.0% (line 12) and for psoriasis and psoriatic arthritis as 6.3% (line 14). This article was corrected online.