LETTERS TO THE EDITOR

LYMPHANGIOMA CIRCUMSCRIPTUM MASQUERADING AS LARVA MIGRANS

To the Editor,

A 30-year-old man presented with mildly itchy eruptions on right upper limb that had been present for last 3 months. The lesions had commenced on right forearm and gradually spread to the upper arm. There was no history of any operative procedure performed on the arm or local radiation therapy for any tumour. No family history of similar disorder was forthcoming.

Cutaneous examination revealed serpiginous raised shiny skin lesions of irregular shape over the right forearm (flexor aspect), elbow and upper arm (medial and flexor aspects). Some of these lesions were forming arcuate pattern. The width of these lesions was varying from 1 mm to 3 mm and were easily compressible. On puncturing the lesions exuded clear watery fluid. Rest of the cutaneous and systemic examination was unremarkable.

A clinical diagnosis of larva migrans was initially made, as this disease is endemic here and patient was put on oral albendazole 400 mg twice daily for 3 days, without any relief. Hence, skin biopsy was performed. Microscopic examination of section from skin lesions showed dilated lymphatic vessels lined by single layer of endothelium, containing lymph. The overlying epidermis was thinned out at places. In other areas, the epidermis showed hyperkeratosis and papillomatosis. There was also mild lymphocytic infiltrate in the dermis. A final diagnosis of lymphangioma circumscriptum was made on the basis of histopathologic findings.

The cutaneous lymphangioma, benign lesions of the lymphatic vessels, though uncommon, occurs in several forms that differ in histologic characteristics and prognosis.[1] They may be broadly classified into superficial lymphangioma circumscriptum and deep lymphangioma cavernosum.[2] The former, usually manifest as irregular clusters of vesicles forming no particular pattern, but in occasional cases forms linear or band like lesions.[3] It has been further subdivided into classical and localised forms on the basis of size of the lesion. The lesions of the classical type may occur over any part of the body, but are mostly concentrated over the proximal parts of limbs and the adjacent parts of limb girdles.[2] Usually, it manifests at birth or soon afterwards,[2] may become clinically apparent at any age.[1] The atypical serpiginous skin lesions mimicking cutaneous larva migrans in our case were observed for the first time at the age of 30 years.

Many authors distinguish between the lymphangioma circumscriptum that arise de novo and lymphangiectasia that occur subsequent to surgical operation or irradiation. Clinically and histologically, the lesions are usually indistinguishable and differentiation is often made on the basis of clinical history.[1,2] The histopathological diagnosis of lymphangioma is established by the presence of thin walled vascular channels that are empty or contain eosinophilic homogeneous material (lymph) and few or no erythrocytes. Characteristically, these channels show widely spaced endothelial nuclei lining, irregular lumen and absence of muscular layer surrounding the endothelial lining. The changes in the tissue around these vessels vary with different types of lymphangioma.[1]

Devinder M Thappa, B R Garg, C Ratnakar
Pondicherry

References

1. Flanagan BP, Helwig EB. Cutaneous lymphangioma. Arch Dermatol 1977; 113: 24-30.
2. Peachey RDG, Lim CC, Whimster LW. Lymphangioma of skin. A review of 65 cases. Br J Dermatol 1970; 83: 519-27.
3. Francis AG. Lymphangioma circumscriptum cutis. Br J Dermatol 1893; 5 : 33 and 65.

PEG - 200 WITH 12% SALICYLIC ACID OINTMENT IN PITYRIASIS AMIANTACEA

To the Editor,

A 40-year-old woman presented with scaling over the scalp and non-cicatricial alopecia for 2 years. She had been treated with various topical preparations such as betamethasone-salicylic acid ointment and selenium sulphide shampoo without much relief. Examination revealed masses of yellowish scales adherent to the scalp. KOH preparation for fungus was negative. A diagnosis of pityriasis amiantacea was made, and a sample of the scales was tested for solubility in the following organic solvents : absolute alcohol, acetone, ether, isopropyl alcohol, liquid paraffin, olive oil and polyethylene glycol (PEG-200). The scales were found to be most soluble in PEG-200, and the patient was advised topical application of PEG-200 with 12% salicylic acid and a tar-containing shampoo. At the time of review a month later, she was asymptomatic with minimal scaling on examination. No changes in hair texture were noticed.

Pityriasis amiantacea is a disease of the hair follicles manifested by thick asbestos-like laminated scales on the scalp.[1] Topical application of oil of Cade ointment or a tar/salicylic acid ointment has been recommended to eliminate the abundant scales.[2] Our experience leads us to suggest that topical application of PEG-200 with 12% salicylic acid is effective in treatment of pityriasis amiantacea.

Anis Shah, SD Shenoi, CR Srinivas
Manipal

References

1. Arnold HL, Odom RB, James WD. Diseases of the skin appendages. In : Aåerews' Diseases of the skin. 8th edn. Philadelphia : WB Saunders, 1990.
2. Dawber RPR, Ebling FJG, Wojnarowska FT. Disorders of hair. In : Textbook of Dermatology (Champion RH, Burton JL, Ebling FJG, eds). 5th edn. Oxford : Blackwell, 1992.

CIPROFLOXACIN-INDUCED BULLOUS FIXED DRUG ERUPTION

To the Editor,

Ciprofloxacin is in use since 1986.[1] Due to its potent activity against both gram positive and gram negative organisms, excellent tissue penetration, good results in skin and soft tissue infections and twice a day dosage schedule; ciprofloxacin remains the most popular antibacterial among the dermatologists. However, adverse reactions like rashes and photosensitivity may occur. A single case of fixed drug eruption (FDE) due to ciprofloxacin has been reported earlier in a Japanese patient.[1] A novel case of bullous FDE is reported in an Indian patient.

A 25-year-old pharmacist was first seen in early May 1995 with a brownish-black circular patch with a central bulla measuring 1.25 cm by 1 cm in diameter and an erythematous halo on the dorsum of his right hand. He had earlier developed pharyngitis and took ciprofloxacin 500mg twice daily on his own. On the 5th day he developed erythema on his right forearm and hand which subsequently turned dark with a central bulla.