

Exudative Erythema Multiforme Around Nevi

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To the Editor:

There are several types of dermatosis that may occur around the melanocytic nevi, although there are few reported cases of each of these. The most representative of these dermatoses is halo nevus¹ (Sutton nevus, *leucoderma acquisitum centrifugum*), but there are other named examples including Meyerson nevus² (halo dermatitis), targetoid nevus,³ and a form of exudative erythema multiforme around the nevi (nevocentric EEM).⁴

The most common nevocentric dermatosis is Sutton nevus or halo nevus,¹ recognized by the presence of a colorless halo around the nevus that has been related to an immunological process caused by the nevus itself. In 1971, Meyerson² described some patients with scaly erythema around the nevi—confirmed by histology to be a spongiotic dermatitis—that resolved spontaneously.^{5,6} Targetoid halo nevus is another condition reported around melanocytic nevi—this is believed to be an immune phenomenon caused by halo nevus that resolves following removal of the nevus.³ There is also one case of nevocentric psoriasis described by Shifer et al⁷ in 1992. There are very few cases of nevocentric EEM reported in the literature, and, unlike the case of our patient, none of them occurred during pregnancy. Humphreys and Cox⁸ described one case of unknown etiology in 1988 in a patient treated with thiabendazole, but no later case has been related to any other drug. All the cases described have been related to a history of labial herpes, as was the case in our patient. In all the cases described, histology confirmed the presence of a lymphocytic infiltrate in the dermis around the nevi cells, along with keratinocytic degeneration and necrosis in the epidermis, suggestive of nevocentric EEM.^{4,8-10} The progression of this disease is identical to that seen in non-nevocentric EEM, which resolve spontaneously or following treatment with corticosteroids. Some authors use antiviral agents to accelerate healing in herpes, an option we did not consider for our patient.

We present the case of a woman in the fifth month of gestation, with no relevant history except for recurrent labial herpes, who consulted because of redness around several nevi. This initially consisted of halos of erythematous infiltrates covering an area 0.2 cm in diameter around the nevi; as time progressed these changed into concentric targetoid halos around most of the nevi on the body and face (Figures 1 and 2), with some isolated targetoid lesions in areas where there was no nevus. The patient reported lesions on the upper lip compatible with

labial herpes in remission. Clinical and histological study enabled diagnosis of nevocentric EEM. Prednisone 30 mg/d was prescribed and the lesions disappeared within 5 days.

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Conflicts of Interest

The authors declare no conflicts of interest.



Figure 1. An erythematous halo around the nevus can be seen on the neckline.



Figure 2. Skin lesions in greater detail.

References

1. Cornbleet T, Bernstein R, Kroll C. Observations on leukoderma acquistum centrifugum. *Arch Dermatol.* 1960;82:1011-2.
2. Meyerson KB. A peculiar papulosquamous eruption involving pigmented naevi. *Arch Dermatol.* 1971;103:510-2.
3. Del Río E, Aguilar A, Gallego MA. Targetoid halo nevus. *J Am Acad Dermatol.* 1993;29:267-8.
4. Fabrizi G, Massi G. Halo naevus with histological changes resembling epidermal erythema multiforme. *Br J Dermatol.* 1999;141:369-70.
5. Weedon D, Farnsworth J. Spongiotic changes in melanocytic naevi. *Am J Dermatopathol.* 1984;6:257-9.
6. Nicholls DS, Mason GH. Halo dermatitis around a melanocytic naevus: Meyerson's naevus. *Br J Dermatol.* 1988;118:125-9.
7. Shifer O, Tchetchik R, Glazer O, Metzker A. Halo dermatitis in children. *Pediatric Dermatol.* 1992;9:275-7.
8. Humphreys F, Cox NH. Thiabendazole-induced erythema multiforme with lesions around melanocytic naevi. *Br J Dermatol.* 1988;118:855-6.
9. McKenna KE. Naevocentric erythema multiforme associated with herpes labialis. *Br J Dermatol.* 1999;141:954-5.
10. Pariser RJ. Nevocentric erythema multiforme. *JAAD.* 1994;31:491-2.

Symmetrical Peripheral Gangrene and Disseminated Intravascular Coagulation Associated With Pneumococcal Sepsis

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To the Editor:

Symmetrical peripheral gangrene (SPG) is a rare but devastating complication of septicemia. Most cases of SPG are associated with disseminated intravascular coagulation (DIC).

We present the case of a 35-year-old woman who had undergone splenectomy due to abdominal trauma at 3 years of age; she was referred to hospital with fever and severe prostration with onset 6 days previously in the form of fever, myalgia, and dry cough. Tachycardia, tachypnea, hypotension, and fever were all evident in the initial evaluation. Closer physical examination revealed nothing except for the presence of bibasal crackles during the cardiopulmonary auscultation. Initial complementary tests clearly showed the presence of leukocytosis with left shift (leukocytes: 11 600/ μ L [range: 4000-10 000/ μ L], neutrophils: 91% [40%-75%], band forms: 46% [1%-3%]), mixed acidosis, sinus tachycardia, and bilateral pleural effusion with an air bronchogram in the retrocardiac area. Serum biochemistry, coagulation study, biochemistry, and urine sediment, as well as cerebrospinal fluid (CSF) analysis were normal. Due to her hemodynamic state and the initial diagnosis of sepsis caused by encapsulated bacterial respiratory infection, the patient was transferred to the intensive care unit (ICU), where she was stabilized with a volume infusion and perfusion of vasoactive amines and empirical treatment with cefotaxime 2 g every 6 hours and intravenous azithromycin 500 mg/d.

Six hours after admission to the ICU the patient was re-evaluated clinically and petechial skin lesions were found on the acral zones of the extremities, coalescing to form ecchymotic plaques. Peripheral pulses were palpable. A second complete blood count and coagulation study performed at this time were consistent with DIC (platelets: 20 000/ μ L [150 000-400 000/ μ L], prothrombin time: 20 s [10-12.5 s], partial thromboplastin time: 82.5 s [20-40 s], fibrin degradation products: 650 μ g/mL [$<$ 8 μ g/mL], D-dimer: 8947 ng/mL [$<$ 500] ng/mL). Red cell concentrates and platelets, as well as fresh plasma, were administered. The patient's urine tested positive for *Streptococcus pneumoniae* antigen and the same agent was isolated in the CSF culture. Antibiotic susceptibility testing revealed the organism was sensitive to penicillin and treatment was initiated with doses of 4 million units every 6 hours. The patient progressed well clinically over the following days, with the skin lesions healing except on several fingers on both hands where necrosis and dry gangrene with mummification occurred (Figure). When the necrotic areas had been outlined, 15 weeks later, these areas were amputated and reconstruction was completed with flaps.

SPG is an uncommon but well documented syndrome first described by Hutchinson in 1891. It consists of symmetrical gangrene in acral regions with no evidence of large-vessel occlusion or vasculitis.¹ The lesions begin in the form of erythema or purpurial lesions that develop