

usually managed in the community with topical therapies and, if their psoriasis was generalized, only emollients were permitted; and many patients were lost to follow-up.

Despite prolonged photosensitivity with TMP-bath PUVA and 8-MOP bath PUVA, our impression from this study is that the second soak is probably important, though the size of the study did not allow us to reach a definitive conclusion.

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Reactive Arthritis Associated with *Chlamydia trachomatis* Infection: Importance of Screening and Treating the Partner

Artritis reactiva por *Chlamydia trachomatis*: importancia del rastreo y tratamiento de la pareja

To the Editor:

Reactive arthritis, also known as Reiter syndrome, is a seronegative spondyloarthropathy classically defined by the triad of arthritis, urethritis, and conjunctivitis. It develops in the context of a gastrointestinal or genitourinary infection.^{1,2}

The most common skin manifestations are circinate balanitis, keratoderma blenorrhagica, and nail dystrophy, but both the symptoms and their temporal relationship may vary.

We describe the case of a 23-year-old man admitted for sacroiliitis and psoriasiform lesions on the limbs and trunk associated with marked circinate balanitis, nail dystrophy, dactylitis, keratoderma blenorrhagica (Figure 1), asthenia, and bilateral conjunctivitis. The patient reported previous episodes of arthritis, conjunctivitis, and urethritis that occurred after an average incubation period of 3 weeks following symptoms of urethritis, and that improved after the administration of nonsteroidal anti-inflammatory drugs and doxycycline.

Blood tests performed during admission showed elevated levels of C-reactive protein. Rheumatoid factor was not elevated and the tests for autoimmunity, viral serology, and microbiology cultures for microorganisms related to

sexually transmitted diseases were negative. Skin biopsy was compatible with psoriasis, the histocompatibility antigen study was positive for HLA-B27, and imaging studies revealed early signs of enthesitis and asymmetric sacroiliitis. The partner presented no genitourinary symptoms.

A sample of urethral exudate was taken from the patient and cervical exudate from the partner to test for *Chlamydia*



Figure 1 Keratoderma blenorrhagica on the right foot.

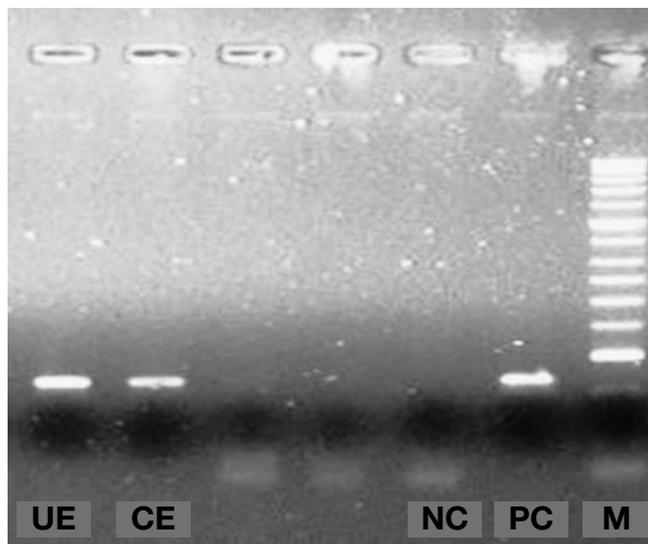


Figure 2 Visualization of the 241pb bands of *Chlamydia trachomatis* cryptic plasmid in the urethral exudate (UE) of the patient and in the cervical exudate (CE) of the partner on exposure to UV of the 1.5% agarose gel. Abbreviations: NC (negative control: distilled water added to the reaction mixture), PC (positive control, type L2434B propagated in McCoy cells), M (molecular weight marker: Bioline HyperLadder II).

trachomatis using the polymerase chain reaction, with amplification of the cryptic plasmid of this bacterium, and subsequent genotype analysis was performed using a different amplification target.

Both exudates were positive for *C trachomatis* (Figure 2) and genotype E was detected in both samples. The patient and partner were treated with doxycycline 100 mg twice a day for 14 days. Both stated they had no other sexual partners.

Monitoring of joint symptoms and the cutaneous manifestations was only possible with strict bed rest, intramuscular treatment with methotrexate 25 mg per week, and the later introduction of naproxen and folic acid. In follow-up after a year of treatment, there was persistence of some joint symptoms and the sacroiliitis was controlled with methotrexate 15 mg/w. The Koebner phenomenon, which has been described previously in this syndrome, was observed after the patient acquired a new tattoo (Figure 3).

The etiology of reactive arthritis is still unknown, but several authors have mentioned the possibility of molecular mimicry between the infectious agent and HLA-B27 causing an immune response to the human antigen.³ The condition could also be provoked by the presence of *C trachomatis* DNA in the synovial fluid, a situation that was detected in some patients.⁴

It is not known why the condition is more common in men, although some authors attribute the gender discrepancy to the high percentage of asymptomatic genitourinary infections in women, in whom the resulting symptoms are classified as seronegative arthritis.⁵ This highlights the importance of screening for these infectious agents.



Figure 3 Koebner phenomenon on patient's arm 2 weeks after a new tattoo was completed.

Testing and treatment for this infection must be undertaken in sexual partners, particularly in women in whom it may be asymptomatic,⁶ as in the present case. If the sexual partners are not treated, systematic reinfection will ensue with recurring outbreaks of reactive arthritis.

In those patients in whom the joint and skin manifestations are resistant to conventional therapy, methotrexate² is an effective alternative, as occurred in this case.

Molecular testing for *C trachomatis* is more sensitive than cell culture, although cell culture is still the technique of choice in complementary tests for diagnosis of reactive arthritis.⁷ Molecular biology techniques are currently recommended for the diagnosis of this agent in both European and US guidelines.^{8,9} Use of these tests with 2 different targets, as was performed in the partner of our patient, enables us to minimize the risk of finding false positives in populations with a low prevalence of this infection.⁶ It is also extremely important that doctors become familiar with the interpretation of these techniques for the detection of this bacterium.

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Multiple Cutaneous Granular Cell Tumors

Tumores cutâneos múltiplos de células granulares

To the Editor:

Granular cell tumor (GCT), described by Abrikossof in 1926, is a rare and usually benign neoplasm considered to be of neural origin.¹ It usually presents as a solitary papule or nodule. Multiple cutaneous lesions such as those found in the case we present^{1,2} are very rarely reported in the literature.³

Our patient was a 41-year-old white man with no relevant past history who, for 3 to 7 years, had had 4 slow-growing subcutaneous tumors of between 1.5 and 4 cm in diameter located on the left hip, the left iliac fossa, the right thigh (Figure 1), and the right scapular region. They were painful on palpation and not adherent to deep tissues. Magnetic resonance imaging showed that the lesions were located in the subcutaneous tissue and were independent of the fascia and underlying muscle (Figure 2). The skin biopsy showed a diffuse proliferation of polygonal cells with abundant granular eosinophilic cytoplasm, no necrosis or mitoses, and positive staining for S-100, vimentin, and CD68 (Figure 3), allowing us to confirm the diagnosis of granular cell tumor for all the lesions. The plastic surgery department performed a wide excision of the lesions. After 19 months of follow-up, there were no signs of recurrence, metastatic disease, or new lesions.

GCT is a rare tumor occurring in 0.017% to 0.025% of surgical specimens.² In patient series reported in English-language journals it most often affects black adult women (30-60 years), but in a Spanish series men aged 10 to 50 were predominant.³ Its most common location is the tongue (40% of cases), followed by the skin and the subcutaneous tissue of the chest and limbs, although it has been reported in many organs.^{1,2,4} Congenital⁵ and familial⁶ cases have also been reported. In 4.5% to 13% of cases it has been reported in association with other types of neoplasm.^{1,6,7}

Clinically, it is a firm, solitary, circumscribed, asymptomatic nodule that is usually less than 3 cm in diameter; it may be pruritic or painful. The diagnosis is not usually suspected clinically¹⁻⁴ but depends on histology.

Histology shows it to be an ill-defined, nonencapsulated tumor composed of sheets, nests or cords of rounded or polygonal cells with a small central nucleus and abundant eosinophilic cytoplasm packed with coarse, diastase-resistant, periodic acid-Schiff-positive granules that represent phagolysosomes.^{1,3} The overlying epidermis may be normal or show pseudoepitheliomatous hyperplasia.¹⁻⁴

Immunohistochemistry reveals that a high percentage of granular cells are positive for S-100 (98-100%), neuron-specific enolase (98-100%), and vimentin (100%) and a lower percentage for CD57 (69%) and CD68 (65%).⁸

The treatment of choice is simple excision of the entire lesion with adequate surgical margins. Radiotherapy and chemotherapy are not recommended.¹⁻⁴



Figure 1 Detail of the subcutaneous lesion located on the right thigh.