appeared on her foot. The patient tried her right shoe on her left foot, and after a few hours lesions appeared on the foot along with distant lesions on her chest.

Patch testing was performed with a standard series and a shoe series, the latter proving positive for 4-aminoazobenzene; however, there was no cross-reactivity with paraphenylenediamine (Figure 3). The rubber and dyed leather of the shoe were also patch tested and the reaction was positive. The definitive diagnosis was contact dermatitis caused by shoe dye. Since she stopped using the shoes, the patient has not presented further lesions.

Therefore, we describe a case of unilateral contact dermatitis caused by footwear. This atypical presentation delayed diagnosis and led us to consider different options, such as factitious dermatitis. Footwear contact dermatitis typically presents bilaterally and commonly affects the dorsa of the feet. Diagnosis is made difficult by the existence of atopic dermatitis and pre-existing or overlapping infection. Moreover, other conditions that can be misdiagnosed, such as nummular eczema, tinea pedis, dyshidrotic eczema, contact dermatitis caused by topical medication, etc.[1,2]

4-Aminoazobenzene is an intermediate in the production of diazo dyes used in the textile and footwear industry. Cross-sensitivity between azo dyes and para-amino compounds such as phenylenediamine is common,[3,4] although in our case we did not observe cross-reactivity.

Figure 2. Right shoe. The ink had stained the internal sides of the shoe in the area where the patient presented the blisters.

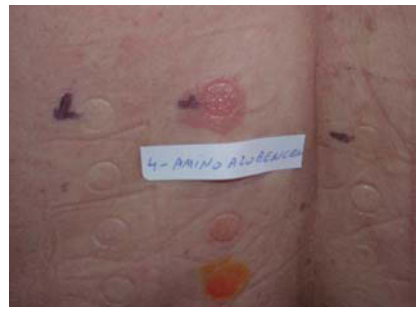

Figure 3. Positive patch test with 4-aminoazobenzene.

Since the year 2000, the Contact Unit of the Dermatology Service of Hospital General Universitario in Valencia, Spain, has recorded 82 cases of contact dermatitis due to footwear. As was the case in other series,[5] potassium dichromate was the most common allergen (86.5%), and other less commonly involved allergens were 4-tert-butylphenol-formaldehyde resin, 2-mercaptobenzothiazol, nickel, and paraphenylenediamine. Only 2 of our cases involved aminoazobenzene, and in 1 there was cross-reactivity with paraphenylenediamine. The mean age of diagnosis was 34 years and the ratio of men to women was 1:3. This dermatitis presented most commonly on the dorsa of the feet. The conditions diagnosed before contact dermatitis were dyshidrotic eczema, neurodermatitis, lichen simplex chronicus, psoriasis, and dermatitis artefacta, as in our case.

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Two Cases of Hypertrichosis Cubiti

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To the editor:

Hypertrichosis cubiti, also known as hairy elbows syndrome, is an uncommon form of localized congenital hypertrichosis in which an excessive amount of long, fine, lanugo-type hair is found on skin of normal texture and morphology. The hair growth follows a bilateral symmetrical distribution and affects the extensor surface of the distal third of the upper arms and the proximal region of the forearms. The condition usually appears

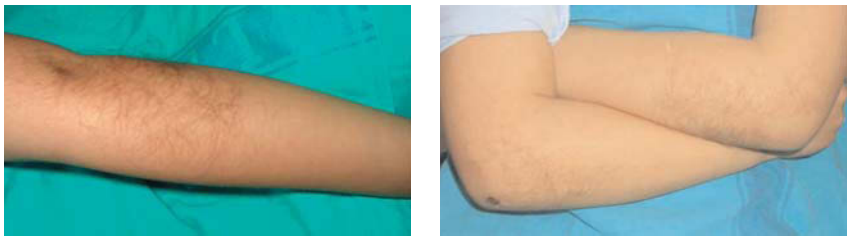

Figure 1. Areas of hypertrichosis on the upper arms and forearms with detail in the image on the right.

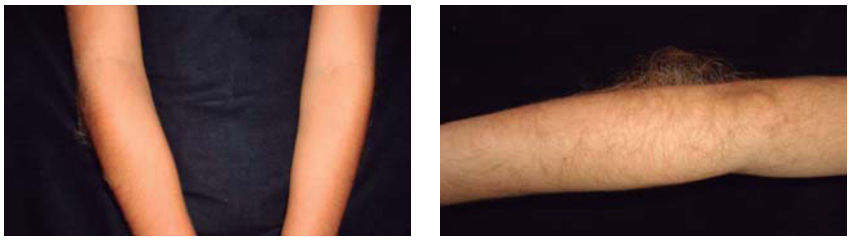

Figure 2. Bilateral symmetrical hypertrichosis with detail in the image on the right.

in early infancy (1-3 years). With time, the hair becomes thicker, reaching maximum thickness at age 5. It usually regresses in adolescence, but in some cases persists throughout life.[1-3] The syndrome may present in sporadic or familial forms and its mode of inheritance is unclear. It is associated with short stature in about 50% of patients; such patients may present other malformations, the most common of which is facial assymetry.[3,4]

Two girls, aged 6 and 10 years, with the sporadic form of the syndrome were recently referred to our department by the pediatrics department. The girls were unrelated and had no relevant personal or family history. Both had suffered from the condition since the age of 2-3 years. A large amount of fine long hair was observed in both patients, dark in 1 case (Figure 1) and blond in the other (Figure 2). The hair was distributed over the distal region of the upper arms and the proximal region of the forearms. There was no excessive hair growth in any other area. The patients' height, weight, and intellectual development were normal. Blood tests (complete blood count; biochemical analysis; liver profile; thyroid function profile; and plasma cortisol, testosterone, and dehydroepiandrosterone sulfate levels) showed no abnormalities. The patients were advised to lighten or shave the area until the condition subsided in adolescence.

Hypertrichosis cubiti was first described by Beighton[5] in 1970 in twin brothers belonging to an Amish family. Of the few cases reported, approximately 50% have been associated with short stature or with intrauterine growth retardation.[3,4] It is in such children that other abnormalities such as facial dysmorphia, abnormalities of the extremities, delays in language development, attention deficit, mental retardation, and mobility difficulties may be found.[6,3] Our 2 patients presented none of these abnormalities, and the syndrome was considered a purely esthetic problem. As was observed in our patients, additional tests do not provide information of interest, and consequently, exhaustive studies are unnecessary.[1,2]

Skin biopsy has been performed on only 2 occasions,[7,8] together with a trichogram in 1 case.[7] The trichogram showed 90% of the hair follicles to be in anagen, 9% in telogen, and 1% in catagen. This would explain the greater length of the hair, as occurs in the scalp.

Some authors suggest that the syndrome may be explained by mosaicism,[6] based on the distribution of excess hair, which is confined to very localized areas and resembles that of cutaneous lesions with mosaicism; others consider it a nevoid condition of the hair follicles.[7,9]

Hypertrichosis cubiti may therefore be part of a complex syndrome with varying manifestations. It is probably more common than it would appear from dermatology practice, but in cases with no associated malformations the only reason for consultation is its psychological and esthetic repercussions at a certain age. When associated with other abnormalities, these are usually identified first. In our opinion, if the condition is observed at a young age, the patient should be followed by a pediatrician, who can monitor growth and check for possible associated malformations; at later ages, as in our patients, it is advisable to reassure parents with respect to the course of the condition.

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Management of a Patient With Calciphylaxis and Requiring Anticoagulant Therapy

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To the Editor:

The different disorders associated with calciphylaxis include the possible relationship with oral anticoagulants,[1] nadroparin calcium,[2] and hypercoagulable states linked to lower concentrations of proteins S or C.[1] The disorder most commonly associated with calciphylaxis, however, is chronic renal failure,[3,4] with between 1% and 4% of these patients suffering from calciphylaxis.[5] Calciphylaxis has also been observed in association with neoplasia, hyperthyroidism, proteinuria,[1] rheumatoid arthritis,[6] and alcoholic cirrhosis.[7]

The pathogenesis remains obscure, although abnormal calcium and phosphorus metabolism (elevated calcium-phosphate product and high levels of parathyroid hormone),[3,8] inflammation,[9] and the presence of a hypercoagulable state[3] have been observed and may lead to vascular and extravascular calcification.

The foregoing leads us to ask several questions: what attitude should be adopted in the case of a patient with calciphylaxis who requires anticoagulation therapy? What are the available antithrombotic alternatives? Which is the most recommendable option?

We present the case of a 58-year-old man with calciphylaxis who was receiving anticoagulant treatment with acenocoumarol due to ischemic heart disease that had been treated with a double coronary artery bypass graft and who had severe pulmonary hypertension, tricuspid insufficiency, and right ventricular dilation and hypokinesis. The patient visited the dermatology outpatient clinic with painful skin lesions on the legs that had appeared 10 days previously. The lesions were between 3 and 4 cm in diameter with a necrotic base and erythematous borders, and the patient was undergoing hemodialysis due to chronic renal failure. The patient presented secondary hyperthyroidism with high levels of aluminium (as a phosphorous chelating agent) but normal levels of calcium, phosphorous, and alkaline phosphates, along with anemia, high blood pressure, and dyslipidemia. The diagnosis of calciphylaxis was confirmed following a pathological study of the lesion biopsy.

In patients diagnosed with calciphylaxis, it is reasonable for both oral anticoagulant therapy and therapy with both unfractionated heparin and low-molecular-weight heparin calcium (nadroparin calcium) to be omitted as they may give rise to calcium deposits.[10] The following are proposed as recommendable alternative anticoagulant therapies: fondaparinux sodium and low-molecular-weight heparin sodium (preferably tinzaparin in patients who also present renal failure[11]), with the clear aim of avoiding exacerbation of the calciphylaxis and the instability inherent in oral anticoagulant therapy in patients with a poor clinical prognosis.

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