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LETTERS TO THE EDITOR

Compliance with Topical Treatment for Bullous Pemphigoid in Patients with a High Level of Dependency for Daily Activities

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To the Editor

In the April 2006 edition of *Actas Dermo-Sifilográficas*, García-Doval et al[1] published an interesting article on the substitution of systemic corticosteroid therapy with topical corticosteroids in patients with generalized bullous pemphigoid. We would like to congratulate the authors of this article on establishing that treatment with high-potency topical corticosteroids can represent an effective alternative for many of these patients—following the same line taken in other studies published by that hospital and by other work groups.[2] Similarly, we have observed good control of bullous pemphigoid in patients treated solely as outpatients with high-potency topical corticosteroids in recent years. However, we have also observed some failures of this approach in high dependency patients. We believe that, at least in some cases, this failure can occur as a result of social and health care-related factors rather than to the condition itself. In our experience, it is also worth taking these factors into consideration when evaluating the effectiveness of topical treatment in this subgroup of patients. The topical treatment and ongoing home care of high-dependency patients with bullous pemphigoid cause a considerable burden of daily work and concern for their family and carers, and the appropriate level of care cannot always be provided over prolonged periods of time in this environment.

Limiting factors in the family environment of the patient (for example: psychiatric conditions or depression) or in relation to health care (poor cooperation or a limited availability of medical or nursing support from the primary health centre) can have a clear influence on the way that treatment is implemented and on its success or failure in the long term. In our experience, these factors can lead to apparent failures of topical treatment, prompting potentially unnecessary admissions that could perhaps have been avoided through greater insistence on topical treatment at home and more pressure applied on care services for a subgroup of patients in whom the complications of systemic treatment can be especially serious.[3]

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Inflammatory Cutaneous Metastasis as a First Sign of Recurrence of Squamous Cell Carcinoma of the Lung

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To the Editor

Cutaneous metastasis occurs in between 0.7% and 9% of cancer patients.[1] This is generally considered a rare and delayed phenomenon in the course of most tumors, although in some cases it may be the form in which the cancer presents.[2] Inflammatory cutaneous metastasis or erysipeloid carcinoma is rare and can be difficult to diagnose.

We present the case of a patient with squamous cell carcinoma of the lung who developed inflammatory cutaneous metastasis as a first sign of tumor progression following response to chemotherapy. The patient was a 65-year-old man who consulted for erythematous lesion on the right

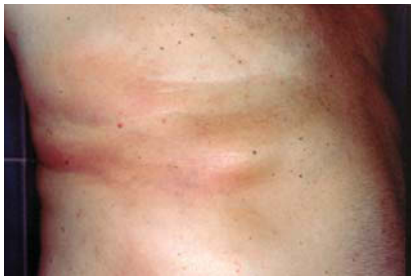

Figure 1. Poorly delimited erythematous edematous plaque on the right hemithorax.

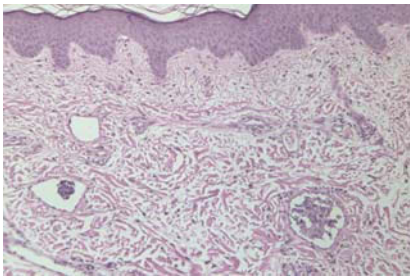

Figure 2. Neoplastic cell infiltration of dermal lymph vessels. Hematoxylin-eosin ×100.

hemithorax that had been present for 1 month. He had given up smoking 24 years previously and was allergic to sulfamides. His medical history included a hiatus hernia, appendectomy, and vasectomy. In June 2002 he was diagnosed with a stage IV (T4N2M1) squamous cell carcinoma of the lung. In July 2002, thoracentesis was carried out to relieve the symptoms of pleural effusion, with the removal of 2000 mL of serosanguineous fluid. Between August and December 2002, he underwent 6 cycles of palliative chemotherapy with intravenous (IV) cisplatin (80 mg/m^2) every 21 days and IV gemcitabine (1250 mg/m^2) on days 1 and 8 of each cycle, obtaining a partial response with remission of the pulmonary nodules observed in imaging studies and a significant reduction in pleural effusion. In July 2003 the patient attended the dermatology department following the appearance of a erythematous edematous plaque on the right hemithorax, with poorly defined margins and an inflammatory appearance, that had been present for 1 month (Figure 1). The patient had no fever or other associated symptoms. Biopsy of the skin lesion revealed invasion of the lymph vessels by a poorly differentiated carcinoma, compatible with a primary lung tumor (Figure 2) In August 2003, a computed tomography scan revealed enlarged lymph nodes in the right axillary region, tumor recurrence in the right lung, and the appearance of new nodular lesions in the lower lobe of the left lung. The invasive lesions in the right hemithorax and the enlarged axillary lymph nodes persisted until the last clinical follow-up examination in September 2003.

Cutaneous metastasis tends to present clinically as nodular, generally indolent, lesions that display progressive growth and are hard to the touch. On rare occasions cutaneous metastasis can present as infiltrated plaques with signs of inflammation, whereupon it is diagnosed as inflammatory cutaneous metastasis or erysipeloid carcinoma.

Inflammatory carcinoma of the breast represents between 1% and 4% of all cases of breast cancer and is the most frequently observed inflammatory carcinoma.[3] However, inflammatory metastasis has also been described in isolated cases of other types of cancer, including cancer of the bladder, colon, ovary, pancreas, parotid gland, prostate, stomach, tonsils, and uterus, as well as melanoma, squamous cell carcinoma of the larynx, and squamous cell carcinoma of unknown origin.[3-6] Neoplastic cell infiltration of the dermal lymphatic vessels is the common denominator behind the clinical characteristics of the lesions, leading subsequently to erythematous infiltrates that resemble severe infections like erysipelas or cellulitis.[7] The skin tends to be hot, painful, edematous, erythematous, and with a slightly raised edge around the lesion. Unlike true skin infections, in erysipeloid carcinoma there is no fever, shivering, or leukocytosis, microbiological cultures give negative results, and the course tends to be slower, with lesions present for weeks or months.[7]

The incidence of cutaneous metastasis in patients with lung cancer varies between 2.8% and 8.7%. It is most frequently found on the head and neck, most commonly in the form of nodular lesions.[8] Inflammatory cutaneous metastasis of lung cancer has been described on very few occasions, and in the 3 cases we found described in the literature, it was associated with adenocarcinoma of the lung.[7,9,10] Our patient had squamous cell carcinoma of the lung and the inflammatory cutaneous metastasis was the first sign of tumor recurrence following the response to chemotherapy. In the cases described by Hazelrigg and Rudolph[7] and Homler et al[10] the lesions were attributed to spreading to the skin following exploratory thoracotomy or thoracentesis. In our case the cutaneous lesions appeared on the right hemithorax and, as in the aforementioned cases, it is possible the thoracentesis carried out a year earlier could be responsible for the spread to the skin via the chest wall.

We suggest that squamous cell carcinoma of the lung should be taken into consideration as a possible cause of inflammatory cutaneous metastasis and that this diagnosis should be considered in all oncology patients with persistent cutaneous lesions that show signs of inflammation and do not respond to treatment with antibiotics.

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Acneiform Eruption Secondary to Cetuximab With Pseudomalignant Histopathological Changes

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To the Editor:

Cetuximab (C225) is an antibody against epidermal growth factor receptor (EGFR) that inhibits cell proliferation.[1] The most commonly reported adverse effect is follicular acneiform eruption.

We present the case of a 69-year-old man with a history of hypertension and type 2 diabetes mellitus. In July 2004, the patient was diagnosed with adenocarcinoma of the sigmoid colon and underwent localized resection. Treatment with cetuximab was started when a computed tomography (CT) scan of the thoracic and abdominal region carried out to assess tumor spread revealed enlarged retroperitoneal lymph nodes. One week after he completed the second cycle of cetuximab the patient presented with a monomorphic erythematous papulopustular follicular eruption that had appeared abruptly on his face, scalp, and back (Figure 1). Examination of the dermis revealed edema and a perivascular and interstitial inflammatory infiltrate composed of lymphocytes, plasma cells, isolated eosinophils, and large cells with a grayish cytoplasm, along with pleomorphism, binucleation, prominent hyperchromatic nucleoli, and the presence of isolated mitotic figures (Figure 3). Immunohistochemistry of these cells was positive for CD-68 and lysozyme and negative for myeloperoxidase, and periodic acid-Schiff staining was negative, confirming their histiocytoid character. The lesion was a cetuximab-induced acneiform eruption that improved after treatment with topical benzoyl peroxide and oral minocycline.

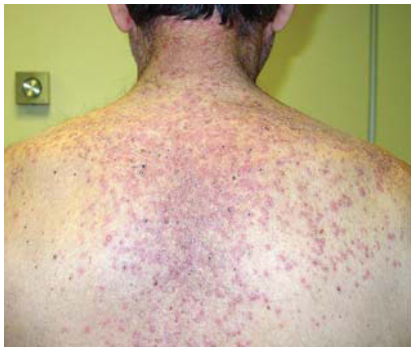

Figure 1. Papulopustular eruptions on the back.

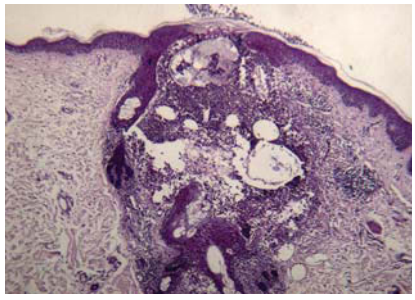

Figure 2. Histology of a papulopustule showing neutrophilic folliculitis with negative periodic acid-Schiff staining. (×25.)

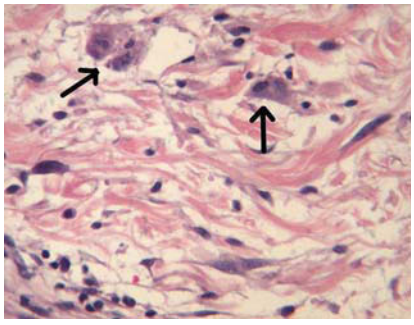

Figure 3. Atypical binucleated histiocytes (arrows). (Hematoxylin-eosin, ×200)