

in the literature, even though it is an exceptional side effect. However, an association with oxaliplatin cannot be ruled out, despite the absence of published case reports.

The cause of this drug-related hyperpigmentation is unknown, although there may be a mechanism common to all the cited chemotherapy drugs. These substances could increase pigmentation by means of melanocyte-stimulating hormone or by direct stimulation of melanocytes themselves.⁵ The reaction could also be provoked by higher concentrations of the drug in areas of skin experiencing greater blood flow.⁹

This pigmentation is clinically reminiscent of erythema ab igne, which has been related to long-term exposure to heat below the burn threshold. Such exposure to heat would cause erythema followed by postinflammatory pigmentation with this cutaneous vascular pattern.

In our patient, as in the cases described in the literature, the hyperpigmentation did not recur in later cycles, although the drug was maintained and the dosage remained unchanged. It is therefore possible that the patient presented hyperpigmentation due to local toxicity of the drug, resulting from increased blood flow to this location,

as would occur, for example, with an increase in ambient temperature.

This would be interpreted as postinflammatory pigmentation of the overlying skin taking a cutaneous vascular pattern—similar to the supravenuous hyperpigmentation described in association with 5-fluorouracil—due to subclinical phlebitis induced by the infusion or by localized hyperthermia.^{6,7}

We conclude that this case of reticular hyperpigmentation was an exceptional side effect of 5-fluorouracil, even though the same symptom has also been associated with the infusion of other antineoplastic agents. We suggest it was produced by a higher concentration of the drug in areas of skin that experienced greater blood flow. It occurred as an asymptomatic and persistent cutaneous reaction that did not require any modification of the prescribed oncological treatment.

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Imported Donovanosis in an Adolescent Girl

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To the Editor

Donovanosis or granuloma inguinale is a granulomatous, progressive, ulcerative bacterial infection caused by *Calymmatobacterium granulomatis*.

This infection is rare in children or adolescents.^{1,2} However, we present the case of a 12 year-old girl seen at our hospital, after referral from the Tangiers Hospital, Morocco, with an ulcerative

genital lesion that had been present for 1 year, diagnosed as squamous cell carcinoma. The patient had been raped by a family member some months before the lesions appeared. Examination



Figure 1. Painful ulcer measuring 5-6cm in diameter on the labia majora.

revealed a painful ulcer 5-6 cm in diameter on the labia majora (Figure 1). Ulceration was also present in the mouth, acquired through direct sexual contact with the attacker's genitalia (Figure 2).

Laboratory tests, serological tests for the human immunodeficiency virus, syphilis, hepatitis B and C, and routine bacteria cultures gave negative results.

The skin biopsy revealed the presence of short, thin bacteria which stained positively with Giemsa solution and which were located within the cytoplasm of the dermal macrophages, forming organisms known as Donovan bodies.

Clinical examination and biopsy findings led to a diagnosis of donovanosis.

Doxycycline 200 mg/d was prescribed, and clinical improvement in the lesion occurred in the first 7 days. Treatment was maintained for 3 months until the lesion was totally healed.

Donovanosis or granuloma inguinale is a contagious disease produced by *C granulomatis*, and is mostly seen in adults



Figure 2. Ulcer in the oral cavity acquired through sexual contact.

aged between 30 and 50 years old in tropical or subtropical regions. The disease is commonly, but not exclusively, transmitted by sexual contact with an infected person.³ It is a very rare infection in children^{1,2} and cases in the pediatric population tend to be transmitted via the birth canal.

The clinical form tends to be characterized by localized nodules in the genital area that usually become ulcerated. Of the extragenital sites, which tend to be rare, the oral cavity is the most common as a result of the practice of oral sex. Hematogenous spread is very uncommon, and occurs almost exclusively in pregnant women.³

There is no specific culture medium for *C granulomatis*, as it has rarely been cultivated successfully by research laboratories.

Polymerase chain reaction techniques have been developed on the basis of genetic similarity to bacteria of the *Klesiella pneumonia* and *rhinoscleromatis* genus,⁴ although this technique is not routine.

Differential diagnosis must be made with Behçet disease, squamous carcinoma, Crohn disease,⁵ pyoderma gangrenosum, syphilis, and canker.

Treatment with trimethoprim-sulfamethoxazole, doxycycline, or azithromycin is recommended.⁶

Antibiotics must be continued until the lesion is fully resolved.

This is the first case in Spain of a female adolescent being treated for

imported donovanosis, as all previous cases had been in adults.⁷⁻⁹

This new case illustrates the need for knowledge of imported diseases, which can also affect the pediatric population, given the increased immigration of recent years.

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