oil is considered safe, different skin reactions have been reported in association with its use, including irritative dermatitis, erythema, erythema multiforme-like eruption, linear IgA bullous disease, systemic hypersensitivity reactions, and anaphylaxis.[1,4,7]

In the cases described, we observed positive reactions to 5% tea tree oil and 20% colophony, considered as present relevance and cross reaction, respectively, in both patients. The cross reaction with colophony has been previously described in the literature.[8,9] In the first case, we expanded the initial epicutaneous study to include α-pinene and limonene, which were both negative. Limonene is one of the components of tea tree oil and a positive result for this substance may be key to suspecting a possible contact allergy to tea tree oil.

Tea tree oil is an essential oil with considerable sensitizing power, especially in its oxidized form. Although allergic contact dermatitis due to this oil has been considered rare in our setting, the incidence has increased in recent years due to the popularity of alternative therapies and its presence in different commonly used products. In the epicutaneous tests, a positive result for limonene may be the key to suspecting possible contact allergy to tea tree oil and a cross reaction with colophony may be present.

Since 1991, approximately 100 cases of allergic contact dermatitis due to tea tree oil have been reported, of which only 5 have been reported in Spain.[10] We report 2 new cases, one of which is the first case of allergic contact dermatitis due to this essential oil in a girl in Spain.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

References

1. Crawford GH, Sciacca JR, James WD. Tea tree oil: cutaneous effects of the extracted oil of Melaleuca alternifolia. Dermatitis. 2004;15:59–66.
2. Larson D, Jacob SE. Tea tree oil. Dermatitis. 2012;23:48–9.
3. Aberer W. Contact allergy and medicinal herbs. JDDG. 2007;0(0), 071005084210002.
4. Pazyar N, Yaghoobi R, Bagherani N, Kazerouni A. A review of applications of tea tree oil in dermatology. Int J Dermatol. 2013;52:784–90.
5. Rutherford T, Nixon R, Tam M, Tate B. Allergy to tea tree oil: retrospective review of 41 cases with positive patch tests over 4.5 years: allergy to tea tree oil. Australas J Dermatol. 2007;48:83–7.
6. Hammer KA, Carson CF, Riley TV, Nielsen JB. A review of the toxicity of Melaleuca alternifolia (tea tree) oil. Food Chem Toxicol. 2006;44:616–25.
7. Khanna M, Qasem K, Sasseville D. Allergic contact dermatitis to tea tree oil with erythema multiforme-like id reaction. Am J Contact Dermatitis. 2000;11:238–42.
8. Selvaag E, Eriksen B, Thune P. Contact allergy due to tea tree oil and cross-sensitization to colophony. Contact Derm. 1994;31:124–5.
9. Groot AC, Schmidt E. Tea tree oil: contact allergy and chemical composition. Contact Dermatitis. 2016;75:129–43.
10. Sanesteban Muruzábal R, Hervella Garcés M, et al. Efectos secundarios de la aplicación tópica de un aceite esencial. Dermatitis alérgica de contacto a aceite del árbol de té. An Sist Sanit Navar. 2015;38.

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Erythema Papulosa Semicircularis Recidivans: A New Entity or a Subtype of Erythema Annulare Centrifugum?*

Eritema papular semicircular recidivante: ¿nueva entidad o subtipo de eritema anular centrífugo?

To the Editor:

Erythema papulosa semicircularis recidivans (EPSR) is a recently described entity characterized by the appearance of semicircular erythematous plaques with a centrifugal extension and of a clearly seasonal nature, starting in spring or summer and resolving spontaneously in colder seasons.[1] The principal differential diagnosis is established with figurate erythema,[2] especially erythema annulare centrifugum (EAC) and, specifically, its annually recurring subtype (AR EAC).[3] We report the case of a patient with recurring annular lesions that oblige us to consider the differential diagnosis between these 2 entities.

A 70-year-old woman with a history of ischemic heart disease, hypothyroidism, thromboembolic disease, and chronic gastritis visited our department in the month of May with a large erythematous plaque in the abdominal region that had appeared 2 weeks earlier and had expanded centrifugally (Fig. 1). The patient stated that the lesion caused pruritus and moderate pain. She had no fever, joint pain, or any other symptoms. In total, the patient had had 6 independent episodes of lesions in a similar location and of similar clinical characteristics. The first episode had occurred 9 years earlier (Fig. 2). All the episodes had begun in the spring or summer months and had resolved spontaneously in the early autumn.

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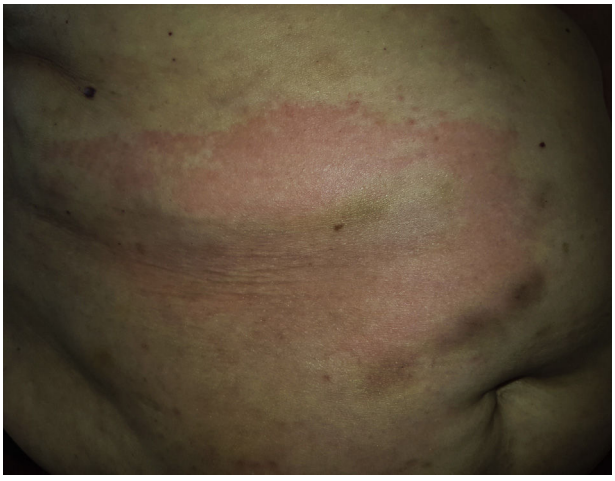

Figure 1 A large semicircular erythematous plaque with a clearly demarcated papular margin and central lightening, located on the abdomen.

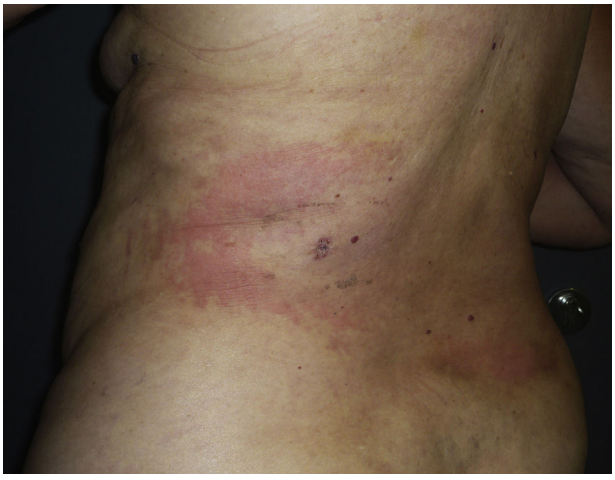

Figure 2 Appearance of the lesion during the first episode, 9 years earlier. The initial lesion already showed a semicircular distribution with clearly defined edges and central lightening.

Physical examination revealed a semicircular erythematous plaque measuring 20 × 15 cm, located on the abdomen, with a clearly demarcated papular margin and central lightening (Fig. 1). Histology showed only a perivascular inflammatory infiltrate composed mainly of lymphocytes, which involved the superficial and middle dermis. The epidermis and deep dermis showed no abnormalities (Fig. 3). Blood tests were performed with a full blood count and biochemistry, and an antibody titer was performed; results were normal.

Treatment with topical methylprednisolone and oral prednisone was prescribed (maximum dosage, 0.5 mg/kg/d) for 15 days, with no clinical response. After the summer, the patient presented for a follow-up visit and showed complete spontaneous resolution of the lesions. The course of the previous episodes was similar.

EPSR was first described in 2012, when Song et al[1] reported a series of 9 patients of Chinese nationality with

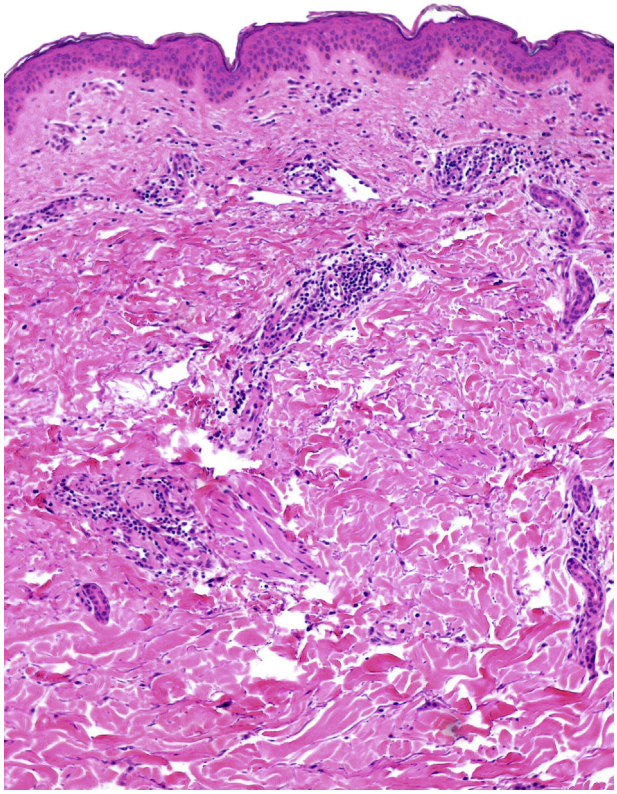

Figure 3 The biopsy shows a perivascular inflammatory infiltrate composed mainly of lymphocytes, which involves the superficial and middle dermis (hematoxylin–eosin).

papuloerythematous eruptions with a centrifugal growth pattern that typically recurred during the warm, humid months. Cases with similar seasonality were subsequently described in Western countries, one of which showed a possible link to a primary pancreas B cell lymphoma.[4,5] The most frequently involved areas are the torso and proximal extremities; the face, palms and soles are not usually involved. Histology usually shows a perivascular lymphocytic inflammatory infiltrate and mild edema of the papillary dermis; all of these finding suggest superficial perivascular dermatitis. No leukocytoclasia or other vasculitic findings are observed.[1]

As mentioned, the principal differential diagnosis is with EAC. Both EAC and EPSR begin as plaques with centrifugal growth and central lightening. Desquamation at the edge of the lesion can be observed in the superficial form of EAC, whereas this phenomenon is not seen in EPSR. Moreover, the size of the plaques tends to be smaller in EAC than in EPSR. Histology of EAC is characterized by the distribution of the perivascular inflammatory infiltrate in a shirt-sleeve pattern; this pattern is not so clearly observed in EPSR.

Although EAC does not usually present as clearly seasonal, descriptions exist of cases in which, just like in EPSR, the lesions appear in the warm months and resolve spontaneously with the arrival of cold temperatures. This subtype is known as annually recurring EAC.[3] Although the etiology of EPSR and EAC is unknown, both may be due to a hypersensitive reaction to different external or internal stimuli.

Infectious diseases, hormone abnormalities or fluctuations, some drugs and foods, and even neoplasias have been linked to EAC lesions. Annually recurring EAC may also involve seasonal environmental factors such as increased temperature or insect bites. A clear causal agent, however, cannot be identified in most cases (idiopathic EAC).

With regard to treatment, topical and systemic corticosteroids may alleviate the pruritus, but they cannot halt the progress of the lesions, which may involve the entire chest, back or neck. Characteristic of EPSR and annually recurring EAC is the gradual and spontaneous regression of the lesions with the arrival of cooler seasons. Long-term follow-up has recorded recurrences in the first 2-5 years, with subsequent definitive resolution.[1] Other publications, however, suggest a longer duration of the disease.[5]

Although EPSR has been described and subsequently reported in high-impact scientific journals, some authors question that it has sufficient clinical pathologic entity to be considered as an independent disease and they prefer to consider it as a peculiar variant of recurring figurate erythemas such as annually recurring EAC.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

References

1. Song Z, Chen W, Zhong H, Ye Q, Hao F. Erythema papulosa semicircularis recidivans. Dermatitis. 2012;23:44–7.
2. Ríos-Martín JJ, Ferrándiz-Pulido L, Moreno-Ramírez D. Aproximación al diagnóstico dermatopatológico de las lesiones figuradas. Actas Dermosifiliogr [Internet]. 2011;102:316–24.
3. García Muret MP, Pujol RM, Gimenez-Arnau AM, Barranco C, Gallardo F, Alomar A. Annually recurring erythema annulare centrifugum: a distinct entity? J Am Acad Dermatol. 2006;54:1091–5.
4. Inoue A, Sawada Y, Ohmori S, Omoto D, Haruyama S, Yoshioka M, et al. Erythema papulosa semicircularis recidivans associated with primary pancreas B cell lymphoma. Eur J Dermatology [Internet]. 2016;26:306–7.
5. Rodríguez-Lomba E, Molina-López I, Baniandrés-Rodríguez O. An atypical figurate erythema with seasonal recurrences. JAMA Dermatology [Internet]. 2018;154:1340–1.

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Abdominal Pseudohernia Due to Herpes Zoster☆

Pseudohernia abdominal por herpes zóster

To the Editor:

After attending the emergency department of another hospital, an 84-year-old man was diagnosed with left abdominal herpes zoster (HZ). Because clinical signs had developed more than 72 hours earlier, no antiviral treatments were administered. One week later, the patient came to our outpatients due to the sudden appearance of an asymptomatic mass in the area affected by HZ. Five years earlier he had developed a rectal neoplasm that was treated with surgery and radiation therapy. Physical examination revealed hyperesthesia and lesions in the crusting phase on dermatomes T10 to T12. Painless, reducible bulging of the abdominal wall that increased with Valsalva maneuvers was evident in the area affected by HZ (Fig. 1). A midline laparotomy scar showed no signs of complication. An abdominal computed tomography scan was requested to rule out abdominal mass or hernia. The results revealed thinning of the abdominal wall without evidence of hernia. An electroneuromyographic study revealed no alterations. Given the temporal relationship between the appearance of the rash and the protrusion, the case was oriented as abdominal pseudohernia due to HZ. After 8 months, the patient showed a complete clinical recovery (Fig. 2).

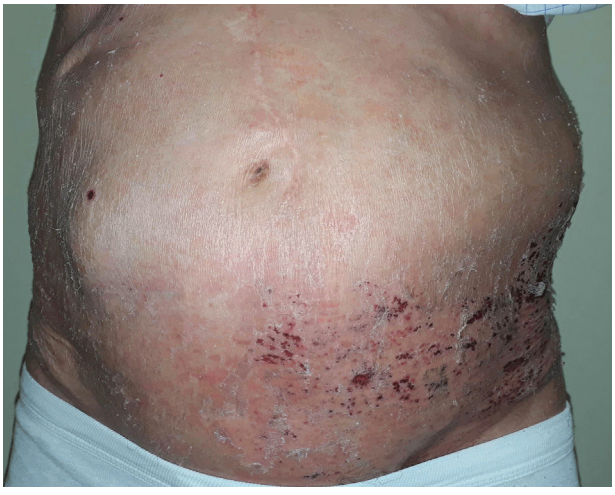

Figure 1 Pseudohernia on the left flank coinciding with herpes zoster in the crusting phase.

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