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A case of pyoderma vegetans associated with Crohn's disease under adalimumab

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Introduction: Pyoderma vegetans is a rare disorder that is clinically characterized by vegetating lesions that coalescence into a plaque with eroded surface, covered by pustules and crusts. The etiology of this condition remains unknown.

Objectives: We describe a 49-year-old man with Crohn disease treated with adalimumab who presented with a large and irregular plaque, covered by a proliferative and vegetative area, located on his right knee. No local trauma had occurred.

Results: Wound culture taken from the lesion was positive for Pseudomonas resinovorans. Histopathologic study revealed epidermal hyperplasia and an inflammatory infiltrate composed mostly of neutrophils. Based on the clinical and histopathological findings, the patient was diagnosed as having pyoderma vegetans. Therapy was initiated with ciprofloxacin 500 mg twice daily and clarithromycin 250 mg twice daily during 6 weeks. The patient showed remarkable response to antibiotic therapy.

Conclusions: We present a case of pyoderma vegetans associated with Crohn disease under adalimumab that showed good response to antibiotic therapy.

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A case of sarcoidal type of necrobiosis lipoidica

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Necrobiosis lipoidica (NL) is an idiopathic disorder usually presented with sharply demarcated yellowish to brownish patch on the extensor surface of lower legs. Histologically, it was characterized by palisading necrobiotic granuloma with a surrounding infiltrate of lymphocytes and histiocytes. Sarcoidal type of NL was a rare histologic variant of NL and it was characterized by a naked epithelioid granuloma with minimal necrobiosis. A 53-year-old woman presented with a 2-year history of confluented brownish macules and patches with yellowish crust and ulceration in both lower leg. Skin lesions were distributed dominantly on the extensor surface of lower legs. She did not complain of any subjective symptoms and did not have any underlying disease including diabetes mellitus. Histologic evaluation from macular lesion and crusted lesion of right lower leg showed mild hyperkeratosis, loss of rete ridge and palisading granuloma parallel to epidermis from upper dermis to subcutaneous layer. Granuloma was composed of epithelioid cells with multinucleated giant cell, few lymphocyte and central necrobiosis and reticulum stain revealed a few reticulum fibers surrounding the granulomas, which was consistent with histologic features of granuloma in sarcoidosis. Chest X-ray and serum angiotensin converting enzyme (47 U/mL) showed nonspecific findings, which suggested no evidence of systemic sarcoidosis. From these findings, she was diagnosed with sarcoidal type of NL and the skin lesion showed improvement with systemic steroid. Herein, we report an interesting case of sarcoidal type of NL, which has rarely been reported in dermatologic literatures.

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4691

A case of rapidly transformed mycosis fungoides

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Introduction: Mycosis fungoides (MF), the most common form of cutaneous T cell lymphoma, typically portends an indolent course. However, transformation of MF to large cell lymphoma is associated with an aggressive course and shortened overall survival. We describe a case of MF with rapid transformation to large cell lymphoma within four months, followed by death less than three months later.

Case report: A 45-year-old female presented with a six-month history of pruritic plaques on her extremities, involving 1.5% body surface area. Biopsy was performed and histology was consistent with mycosis fungoides; clinically consistent with T1b (stage I) disease. She was prescribed clobetasol 0.05% cream and referred to oncology. At initial oncology evaluation, her staging was T3NxM0B0 (stage II-B), with at least one of her plaques having progressed to a tumor. CT of the chest/abdomen/pelvis demonstrated a 1.5 cm left axillary lymph node that was negative for lymphoma involvement on fine needle aspiration (FNA). She was started on methotrexate 7.5 mg weekly. She experienced rapid worsening of her disease with increasing numbers of large tumors, and was referred for radiation therapy. During radiation, her cutaneous tumors improved but she developed massive supraclavicular and axillary lymphadenopathy. FNA and core needle biopsy demonstrated large cell transformation (LCT). The patient completed three cycles of EPOCH (etoposide, prednisolone, oncovin, cyclophosphamide, doxorubicin) with improvement in her lymphadenopathy and cutaneous tumors. However, shortly after completing her third cycle, she experienced slurred speech. Lumbar puncture was performed, and CSF demonstrated lymphomatous CNS involvement. Prior to starting intrathecal methotrexate, the patient was noted to have worsening slurred speech. Head CT demonstrated acute obstructive hydrocephalus. Despite placement of multiple external ventricular drains, the patient's neurologic function continued to decline and she ultimately succumbed to her disease.

Conclusions: This case highlights the known aggressive clinical course associated with LCT of MF. Transformed MF has been shown to have a median time to transformation of 2.3 years, and a median overall survival of 2 years from diagnosis of transformation. Our case illustrates an accelerated time course and emphasizes the need for early oncology evaluation and consideration of LCT with rapid disease progression of MF.

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A case of sarcoidosis arising from an old cosmetic tattoo

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Sarcoidosis is a common systemic disease with the characteristic histopathologic finding of non-caseating granulomata. Skin involvement is seen in 20-35% of cases. Sarcoidal-type granulomatous reaction in tattoos has previously been reported; however, there are conflicting views as to whether such a reaction is due to sarcoidosis versus a foreign body reaction to tattoo pigment. Here, we describe a 52-year-old female who presented to our dermatology clinic complaining of an acute onset of swelling of her eyebrows, fevers, myalgia, and arthralgia of two weeks duration. She reported having had her eyebrows tattooed 8 years prior, and denied any recent cosmetic procedures or trauma to the area. A punch biopsy of her right eyebrow revealed sarcoidal-type granulomatous inflammation in a background of exogenous pigment. Stains for fungal and mycobacterial organisms were negative. Her chest X-ray revealed bilateral hilar adenopathy, and additional labs supported the diagnosis of sarcoidosis. She was treated with systemic steroid and plaquenil with improvement of her skin lesions and joint pain. Our case supports the notion that although exogenous pigments will inevitably be present in tattoos with sarcoidal reaction, such findings should not exclude the diagnosis of sarcoidosis, and a further investigation for systemic sarcoidosis should be considered if clinically indicated.

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