Rosacea Fulminans with Extrafacial Lesions

Sir,

Rosacea fulminans, previously called pyoderma faciale, is a rare conglobate, nodular disease reported to be restricted to the face, only occurring in women (1). The condition responds to topical and systemic corticosteroids, unlike ordinary rosacea. Here we present an unusual case conceived as rosacea fulminans with extensive extrafacial lesions.

CASE REPORT

The patient was a 35-year-old woman with rheumatoid arthritis, who had been treated with oral methotrexate 10 mg weekly for 2 months. She had no history of skin disease. In April 1995 she developed erythema and papulo-pustules on her left cheek. Her rheumatologist stopped the methotrexate treatment and gave her oral prednisolone, decreasing from 30 mg/daily to 5 mg/daily during the next 2 weeks. The lesions spread to the other cheek, with gradual aggravation of the eruptions. From the beginning of May she was treated with tetracycline 1 g daily for rosacea by a dermatologist. In the next 5 days she considerably worsened, with exudative exanthema, lesions on the trunk and fever, 38°C. At hospitalization in the Department of Dermatology her face and chest were covered by oozing crusts, erythema and papulo-pustules (Fig. 1A). The backs of her hands showed multiple papulo-pustules and erythema (Fig. 1B). There were fewer, but the same type of lesions on the flexor sides of both arms and on the thighs. The oral and the genital mucosa were unaffected. Treatment was started with saline-soaked dressings on the face. Triamcinolone acetonide cream was applied twice a day to her body. Acyclovir and dicloxacillin were given orally until negative microbiological tests were received and tetracycline was again started up. Prednisolone 5 mg daily was continued during hospitalization. The CRP and the sedimentation rate were raised and there was leukocytosis (27,700 WBC/mm$^3$) with neutrophilic granulocytosis (23,600 cells/mm$^3$). All the other laboratory investigations were within the normal range. PCR examinations were negative for both varicella zoster and herpes simplex. Bacteriological investigation of the content of the pustules was negative. Histopathological examination showed superficial pustular folliculitis and Demodex folliculorum were not seen. The temperature normalized and the eruptions began to remit after 2–3 weeks. When discharged, the patient had erythema and a few papulo-pustules in the face, she was still receiving

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Fig. 1. The patient on admission. (A) Erythema and oozing crusts in the face and on the chest. (B) Papulo-pustules on the dorsal side of the hands.

5 mg prednisolone daily and was later followed up monthly at the outpatient clinic. Tetracyclin 1 g daily was continued for the next 3 months. When the patient got pregnant a few months later, she had a flare-up of her rosacea, but only in the facial area.

DISCUSSION

The patient described had extrafacial lesions, which usually points in the direction of acne fulminans. Plewig et al. (2) studied 20 patients with clinical rosacea fulminans and reported that extrafacial lesions were isolated and few, if present. But extrafacial lesions have been described by many authors in patients with ordinary rosacea. The patient described had no comedones, and she had facial erythema, telangiectasia and papules before and after the aggravation. The disease activity was probably too great for tetracycline to show any quickly improving effect the period before admission. Due to the possibility of infection, prednisolone was not increased at hospital admission. Huge leukocytosis (pseudoleukemoid reaction) is reported in other severe dermatoses, like acne fulminans and pustular psoriasis. A methotrexate drug eruption seems unlikely in the present case, since she had a new outburst of facial rosacea in the year after the hospital stay. It is, however, possible that methotrexate caused a flare-up of an “underlying” rosacea.

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Disseminated Morphea in Small Cell Lung Cancer

Sir,

A 34-year-old woman, non-smoker, presented with the complaints of cough and hemoptysis since 1 month. Physical examination and routine laboratory investigations were normal. In the chest radiograph and computerised tomodiagnosis, a mass was observed in the right hilus, with mediastinal invasion. Neuron-specific enolase was elevated at 170 ng/ml (normal, 0–12.5). Bronchoscopy revealed a mass obliterating the lower lobe segment of the right main bronchus. The pathologic diagnosis was anaplastic small cell type lung cancer.

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