tained cholesterol needles. Recently, an observation of pseudo-
lymphoma with inflammatory nodule on a foot and plaques on
both wrists was reported by Castell et al. (12). The lesions
curred after transient antithrombotic therapy and persisted for
4 years until an ultimate biopsy discovered cholesterol crystals
in only one vessel.
Our case emphasizes the possibility of uncommon clinical
and pathologic manifestations such as the features of EIB in
CCE. Moreover, it shows that cholesterol emboli can occur
without plurisystemic features, poor prognosis or symptomatic
atherosclerosis. Finally, it underlines that cholesterol elefts may
easily be missed and that the diagnosis of CCE needs serial
sections and careful examination of specimens of skin or other
organs when biopsies are available.

REFERENCES
1. Kaufman JL, Stark K, Brolin RE. Disseminated atherosclerosis of
d. Les manifestations cutanées des embolies de cristaux de chole-
3. Lebel M, Lassonde M. Erythema induratum of Bazin. J Am Acad
4. Rademaker M, Lowe D, Munro D. Erythema induratum (Bazin’s
5. Kuramoto Y, Aiba S, Tagami H. Erythema induratum of Bazin as a
6. Gaines PA, Kennedy A, Moorhead P, Cumberland DC, Welsh C,
Rutley MS. Cholesterol embolisation: a lethal complication of
7. Schwartz MW, McDonald GB. Cholesterol embolization syn-
drome: occurrence after intravenous streptokinase therapy for myo-
8. Falanga V, Fine M, Kapoor W. The cutaneous manifestations of
cholesterol crystal embolization. Arch Dermatol 1986; 122: 1194–
1198.
reticularis and nodules due to cholesterol embolism in lower ex-
10. Chesney T. Atheromatous embolization to the skin. Br J Derma-
11. Day LL, Atermam K. Hemorrhagic panniculitis caused by athero-
matous embolization. A case report and brief review. Br J Derma-
embolies de cholesterol. Ann Dermatol Venerol 1993; 120: 697–
699.

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Persistent Nodular Lesions Caused by “Bee-sting Therapy”

Sir,
“Bee-sting therapy” is an ancient therapeutic technique, having
a presumed, but not demonstrated, anti-inflammatory and anti-
dolorific action. Bee-sting therapy consists in allowing bees to
sting in and around a painful area. We report the case of a man
with arthritis who developed numerous inflammatory nodular
lesions localized to his lombo-sacral region and manifesting
exactly at the site of the bee stings.

CASE REPORT
A 65-year-old man was admitted because of a nodular dermatitis
localized to his lombo-sacral region. The patient stated that he
had been suffering for many years from arthritis of the spinal
column. For this reason he had been treated with numerous
non-steroidal anti-inflammatory drugs with short-term benefit.
The patient therefore decided to undergo bee-sting therapy.
However, this therapy was suspended one month later, both
because it was ineffective and especially because of the appear-
ance of inflammatory lesions manifesting exactly at the site of
the stings.
Clinical examination showed the presence of numerous round
erythema-nodular lesions, less than 1 cm in diameter, of dif-
ferent colours (from pink to red to purple to brown), with a
central depressed opening from which no material could be
squeezed. The lesions had a smooth surface, a hard-parenchy-
matus consistency and looked like prurigo nodularis lesions
(Fig. 1). Nevertheless, no itch was present, the patient only
complaining of moderate pain.
General physical examination did not show anything path-
ological, with the exception of the arthritis of the lombo-sacral
spinal column, confirmed on radiological examination. Lab-


local and systemic from the clinical point of view. After a bee sting, one can observe reactions with a very wide clinical spectrum: from a moderate local reaction to a fatal anaphylactic reaction (1, 2). The reaction to a sting is determined by the direct pharmacological effect of the venom and by the degree of hypersensitivity acquired to antigenic substances (1, 3). Of great importance are systemic allergic reactions, which can involve the skin with urticaria and angioedema, the respiratory system with laryngeal edema and bronchospasm, and the cardiovascular system with tachycardia, hypotension and shock. These manifestations may be associated or, more rarely, isolated and varying in severity (1, 2). Death due to direct toxicity requires hundreds of stings: almost all deaths occur after one or just a few stings. Therefore, an allergic reaction is by far the most frequent cause of death (2, 4).

As far as local reactions are concerned, the sting is followed by an instant sharp pain. A few minutes later, erythema is seen followed by swelling. Edema may involve a wide area. It has a colour that varies from white to bright red and is of hard consistency; it is particularly marked in the event of stings around the eyes and the mouth. The formation of vesicles, bullae, pustules, ulcers and necrosis is a rare event (3).

The case we have described is an example (perhaps the first one reported in the literature) of a long-lasting subacute inflammatory reaction induced by bee-sting therapy. This therapy for the relief of pain in arthrosis and rheumatic diseases has been known for a long time but has now fallen into disuse almost everywhere (5). Apart from lacking in any demonstrable efficacy, it can provoke sensitization to bee venom, with serious risks to the patient in the event of a subsequent bee sting.

REFERENCES


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