skin lesion was the first sign of a previously undiagnosed lung carcinoma. The clinical differential diagnoses included, among others, keratoacanthoma, basal cell carcinoma and lymphoma.

The prognosis of patients with cutaneous metastasis depends on the type and biological behaviour of the underlying primary tumour and on the particular response to treatment. In cases of skin metastases from lung cancer the prognosis is poor, since involvement of other organs such as brain, liver, bone and adrenal glands may be observed. The average survival after diagnosis of skin involvement from a lung tumour ranges from 3 to 5 months (2). Our patient died of widespread disease 3 months after the appearance of skin metastasis.

REFERENCES


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Ketoconazole as a Therapeutic Modality in Subcorneal Pustular Dermatitis

Sir,

Subcorneal pustular dermatosis (SPD), first described by Sneddon and Wilkinson in 1956 (1), is characterised by 1) superficial flaccid pustules occurring singly or in groups forming annular or gyrate patterns with spreading serpiginous edges, located in the groins, axilla, submammary areas and the flexures of the limbs, 2) subcorneal location of the bulla filled with neutrophils and occasional eosinophils but no acantholysis or spongiosis, 3) negative immunofluorescent studies, and 4) sterile cultures. A majority of the patients respond to dapsone, while corticosteroids are less effective. Some workers have, however, reported treatment failures with dapsone in more than 50% of the patients (1, 2). We report a patient who failed to respond to dapsone and oral corticosteroids but experienced complete remissions on three occasions with ketoconazole.

Ketoconazole has not been used earlier in SPD. A 30-year-old housewife had been having asymptomatic superficial grouped pustules in annular patterns with mild background erythema on the neck, trunk and extremities for the last 3 years. The lesions would appear in crops, which used to dry up in 5–7 days. The severity of the disease was greater in the summer months, with no complete remission at any time. There were no systemic or constitutional symptoms. Cutaneous examination revealed multiple grouped annular flaccid pustular lesions of 2 mm to 4 mm in size, located on the neck, upper chest, back, abdomen, inframammary areas and flexure surface of the upper and lower extremities. There were no mucosal lesions and the systemic examination was normal. Histopathological examination of a lesion revealed a subcorneal bulla filled with neutrophils. There were no acantholytic cells or eosinophils in the bulla. The dermis was unremarkable. Immunofluorescence could not be performed because of non-availability of the services at that time, and culture was not attempted. A diagnosis of SPD was made and the patient was given 100 mg dapsone twice a day with 3 mg betamethasone on alternate days. After 2 weeks of therapy there was no improvement and new lesions continued to appear. At that stage 200 mg ketoconazole per day orally was started and oral corticosteroids were withdrawn. Within 3 days the lesions started subsiding and in 2 weeks all the lesions had subsided completely. The dose of dapsone was reduced to 100 mg per day but ketoconazole was continued in the same dose. After another 4 weeks, while the patient was in remission, ketoconazole was stopped but dapsone was continued. After 2 months the patient had another relapse of the same disease, while she was still receiving 100 mg dapsone per day. She was again given 200 mg ketoconazole per day and the dapsone was stopped. This time also the lesions disappeared completely within 2 weeks. Ketoconazole was continued for 6 weeks, when the patient conceived and the drugs had to be withdrawn. She remained in remission till 2 weeks postpartum when she again had a severe relapse. This time she was treated with 200 mg ketoconazole alone for 3 months and she has now been in remission for about 1 year.

Ketoconazole is primarily used for dermatophytes, Candida and Pityrosporum ovale. The drug acts by inhibiting the cytochrome P-450 enzyme lanosterol 14-demethylase, which is required for conversion of lanosterol to ergosterol (3). It has also been reported to block testosterone synthesis (4), and the sex hormones have been found to influence the function of T-lymphocytes (5), which in turn can cause a variety of immunological effects. We do not know the mechanism of action of ketoconazole in our patient, but complete remissions on three occasions coinciding with the institution of ketoconazole therapy suggest that the remissions could be attributed to ketoconazole.

REFERENCES
An Uncommon Case of the Acute Disseminated Haemorrhagic Bullous Type of Dermatitis Ulcerosa

Sir,

Dermatitis ulcerosa is an uncommon, destructive inflammatory and ulcerating skin disease of unknown cause. It is frequently the cutaneous manifestation of a systemic disease, such as ulcerative colitis, Crohn's disease, polyarthritis, gammopathy and some other conditions (1, 2). As the lesions of dermatitis ulcerosa do not exhibit a specific histopathology, and as other laboratory findings have also been variable and inconsistent, the clinical picture remains the cornerstone for diagnosis of this disease. An atypical bullous type of dermatitis ulcerosa has been recognized to herald preleukemia and leukemia states (3). It has an acute onset and is characterized by steadily enlarging, soft papules and blue-gray, haemorrhagic bullae. We report on a bullous type of ulcerative dermatitis in a patient with multiple systemic diseases, without evidence of leukaemia, and an uncommon course of recovery.

CASE REPORT

The patient, a 38-year-old man with liver cirrhosis since 1989 and diabetes since 1995, was admitted to hospital because of an acute pyelonephritis caused by a concomitant of the ureter in May 1996. The patient received antibiotics (ceftaxoxin, ofloxacin) and an intravenous pig-tail catheter for relief of the concretion. Due to a concomitant disorder of coagulation heparin, dexamethasone and prednisolone were given. After dismissal he developed multiple painful papules and nodules on the buttocks and legs, rapidly leading to ulceration, fever and weakness. When admitted to our department, he was in a septice-like condition with fever up to 39°C. Mouth opening was severely reduced and showed a red, oedematous mucosa with an aphtha on the tip of the tongue. On the buttoc, spreading out to the dorsal upper leg, were two 10×15 cm-sized, painful, ulcerating lesions with bullae on the undermined red margin, discharging haemorrhagic exudate (Fig. 1). Around the rima ani two irregular necrotic demarcated ulcerations were localized. Two crusty reddish ulcerations were on the left knee and on the left lower leg. Furthermore both legs showed multiple solitary purple papules and haemorrhagic lesions. Some of them were spreading out and ulcerated quickly, discharging a serosanguinous exudate. Blood examination, including p-ANCA and c-ANCA, was normal except for elevated BSR, white blood count (10.8×10⁹/l), C-reactive protein (107 mg/l) and thrombocytopenia (81,000/μl), signs of hepatic damage, lowered calcium and phosphorus, hyperγglobulinemia, hypalbuminemia, reduced zine and elevated cardiolipin-IgG. Urine analysis revealed massive proteinuria, albuminuria and elevated alpha-1-microglobulin. Blood culture, culture of blister fluids and Gram's stain were negative. ECG, echocardiography and X-ray of the chest were normal. Abdominal ultrasound and computer tomography of the chest and the abdomen revealed ascites, liver cirrhosis and splenomegaly. Bone marrow showed signs of asymptomatic thrombocytopenia of a megakaryocyte pattern. The histological examination proved oedema, massive neutrophilic inflammation, bullous haemorrhage and necrosis of epidermis and cutis. Furthermore, we saw engorgement and fibrinoid necrosis of small- and medium-sized vessels. Immunohistopathology did not reveal a specific pattern. As the findings of the mouth mucosa pointed towards a gingivostomatitis herpetica, acyclovir 3×500 mg was given i.v. For protection of bacterial superinfection and the known pyelonephritis cefotaxin 3×2 g and flucloxacillin 3×2 g i.v. were applied. Zinc deficiency was balanced. For prophylaxis of myotic superinfection and therapy of gastrointestinal candidosis, fluconazol 200 mg daily was supplied. After 1 week of this therapy the fever disappeared and the patient's condition was stable. When the clinical aspects of dermatitis ulcerosa dominated, a therapy with sulfasalazine 500 mg orally was started and

Fig. 1. Painful, bullous, ulcerating lesion on the dorsal upper leg, surrounded by an undermined red margin on admission.

Fig. 2. Lesion of the upper leg 2 months after onset of the disease, with a ringworm-like epithelization.