addition, all patients had depigmentation in the scars following muscle biopsy (1) (Fig. 1), skin biopsies (2), smallpox vaccination (1), a healed axillary sinus (1) and in long-standing scars (2), whose cause the patients were unable to recall. Three scars were normally pigmented before the onset of systemic sclerosis and depigmented subsequently: 3 scars developed after the onset of disease and were depigmented de novo, while one patient was unable to date the onset of depigmentation in the scar. In no patient did the depigmentation of scars precede the onset of the "salt and pepper" depigmentation of systemic sclerosis.

COMMENT

The patchy depigmentation of systemic sclerosis has many clinical, histological, histochemical and ultrastructural similarities to vitiligo (2). Koebner's phenomenon is known to occur in vitiligo, and a similar process may explain the depigmentation that developed in the fresh scars following trauma, skin and muscle biopsies in our patients. However, depigmentation of the pre-existing scars of smallpox vaccination and previous injury cannot be thus explained.

An alternative explanation is suggested by the clinical observation that focal depigmentation develops on sclerosed skin (2). If this finding indicates that depigmentation supervenes when a critical level of dermal sclerosis has been reached, it could explain the predilection of depigmentation for fibrotic scars, new or old.

While our finding is unlikely to be of any diagnostic value, since it appears in patients with well-established, unmistakable systemic sclerosis, it may provide clues to the pathogenesis of this ill-understood disease.

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Transient Acantholytic Dermatosis after Treatment with 2-Chlorodeoxyadenosine

Sir,

We agree with Meunier et al. (1) that cutaneous reactions secondary to 2-chlorodeoxyadenosine (2-CdA) in patients receiving this drug for the treatment of hairy cell leukemia have rarely been reported. In their retrospective study, 7 of 33 patients (21%) developed cutaneous manifestations while receiving daily intravenous continuous infusion of 2-CdA (at a dose of 0.1 mg/kg/day for 7 days): a maculopapular exanthem in 6 patients and toxic epidermal necrolysis in one (1).

To the best of their knowledge, only one other hairy cell leukemia patient had previously been described who developed a diffuse maculopapular skin rash 4 days after initiating 2-CdA treatment at the same dose schedule (2). However, the cutaneous adverse reaction was attributed to a concurrently administered drug in 6 of these 8 patients (1, 2); in only 2 patients no other drug than 2-CdA was given (1).

Several patients with hairy cell leukemia have been treated at the University of Texas MD Anderson Cancer Center. One of the authors (RK) has managed the care of over 100 hairy cell leukemia patients during the past 9 years; most of these patients were treated with interferon alpha. However, at least 40 patients have been treated with 2-CdA (at a daily dose of 4 mg/m² for 7 days) as either their initial management or subsequent therapy (3). Two of these men developed biopsy-confirmed transient acantholytic dermatosis within 3 days after treatment with 2-CdA had been initiated or had been discontinued. Both patients (ages 45 and 51 years) were febrile; also, there was no improvement of the dermatosis after topical and/or intravenous antibiotics. The lesions were initially suspected to represent a disseminated herpesvirus infection in one of the men; however, there was no improvement after systemic acyclovir therapy. The lesions resolved within 1 to 2 weeks and have not subsequently recurred.

We present the case of a 67-year-old man who was treated with 2-CdA for hairy cell leukemia. Following treatment, he developed a maculopapular rash on his chest and back 4 days after initiating 2-CdA therapy at a dose of 0.1 mg/kg/day for 7 days (4). The dermatosis has previously been described in oncology patients (5). In addition to our 2 patients who were receiving 2-CdA, biopsy-confirmed antineoplastic agent-associated transient acantholytic dermatosis has also been reported in 3 cancer patients who were being treated with recombinant human interleukin 4 for either metastatic renal cell carcinoma (2 men) or metastatic malignant melanoma (1 man) (6).

The pathogenesis of cutaneous manifestations secondary to 2-CdA remains to be definitively established. Meunier et al. (1) speculate that a drug-induced prolonged cytopenia of CD4+ T lymphocytes may have a potential etiologic role in the development of 2-CdA associated dermatoses in hairy cell leukemia patients. In addition to maculopapular exanthems, we add transient acantholytic dermatosis to the list of cutaneous adverse reactions that may be observed in hairy cell leukemia patients receiving 2-CdA.

REFERENCES

White Sponge Naevus Successfully Treated with Tetracycline Mouth Rinse

Sir,

White sponge naevus is a rare autosomal dominant benign condition, characterized by non-painful spongy corrugated whitish plaques of the oral mucosa. More rarely, the nasal, vaginal and anal mucosa may be affected (1, 2). Differential diagnosis includes lichen planus, candidiasis, human papillomavirus infection, verrucous epidermal naevus, hereditary benign intraepithelial dyskeratosis, hereditary mucoepithelial dysplasia and pachyonychia congenita.

We report the sporadic case of a 12-year-old girl with a 6-year history of ill-defined folded white plaques of nearly the entire oral cavity, with predominant involvement of the buccal mucosa (Fig. 1). No lesions were found on the genital and anal mucosa. For the last 3 years the patient had experienced discomfort due to stringy desquamation, which caught between the teeth.

Oral candidiasis was ruled out by repeated negative cultures on Sabouraud’s medium. Histological examination showed groups of pale-staining and vacuolated cells within the spinous layer of a markedly acanthotic epidermis. Results of immunohistochemical studies on paraffin-embedded sections were negative for human papillomavirus DNA. On ultrastructural examination, an atypical paranuclear aggregation of tonofilaments in suprabasal keratinocytes was observed. On the basis of history, clinical appearance, histological and ultrastructural findings a white sponge naevus was diagnosed (1–3).

The therapy of white sponge naevus is often problematic. Antihistamines, nystatin, vitamins and liquid nitrogen have been tried but are mostly unsuccessful. Parenteral penicillin, ampicillin and topical 0.05% tretinoin have been used with varying success. In view of 2 encouraging recent reports our patient was treated with 0.25% aqueous tetracycline mouth rinse twice daily (4, 5). On re-examination after 3 weeks, the oral plaques had considerably flattened and the patient was free of symptoms. In the following months, she was able to control exacerbations by demand application. The mode of action of tetracyclines is unknown but appears to be related not solely to its antibiotic effect (4, 5).

Discoloration of the teeth is a well-known side-effect in children who receive tetracyclines during mineralization of the deciduous or permanent teeth, i.e. before the age of 8 years. Therefore, in children dental examinations should be performed before and during treatment with tetracyclines.

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