Alopecia Areata Occurring in a Patient Receiving Systemic Cyclosporin A

Sir,
Systemic cyclosporin can be effective in alopecia areata (1–3). We here report the occurrence of alopecia areata in a 46-year-old woman receiving 130 mg twice daily of cyclosporin and nitrofurantoin 50 mg daily, after a renal transplantation 7 years earlier. Her primary kidney disease was interstitial nephropathy with a vesico-ureteral reflux. The morning level of cyclosporin before taking the treatment was 170 mg/ml. She had had occipital alopecia areata (5x4 cm) for 2 months, had had no stress, infection or other illness in the weeks or months before the occurrence of alopecia areata. Her family history was negative for immunological diseases. Biological parameters were normal, serum creatinine 126 μmol/l, creatinine clearance 49 ml/min.

Tests were negative for antinuclear antibodies, native DNA, microsomal and thyreglobulin antibodies. The serum C3 level was 0.47 g/l (N: 0.55–1.2), C4 level 0.09 g/l (N: 0.2–0.5), and total hemolitic complement concentration 50 U/ml (N: 400–520). Immune complexes and cryoglobulins were negative. She belongs to HLA group A2,3; B27,35; DR1,3. Kidney HLA group was A2,2; B5,30; DRw5,9.5,3. Serum OKT3/OKT4 report was 1.68. No skin biopsy was performed. Topical propionate of clobetasol was given. One month later, hair regrowth was observed. No change in treatment was realized.

The imputability of cyclosporin in alopecia areata is not proposed. The hypothesis of hair regrowth induced by cyclosporin in alopecia areata is based on a loss of expression of HLA DR follicular keratinocytes and reduced perifollicular T cell infiltration (2,3). Such a hypothesis cannot, however, explain the occurrence of alopecia areata in our case.

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Cutaneous Eyebrow Metastasis in a Patient with Primary Gastric Adenocarcinoma

Sir,
Cutaneous metastases from internal primary tumours are uncommon. Typically, they are associated with an advanced stage of the disease and a poor prognosis. Adenocarcinoma metastatic to skin is usually secondary to a tumour in either the large intestine, lung, breast or ovary (1). We describe the case of an 80-year-old woman with cutaneous metastasis on the eyebrow, in which a diagnosis of gastric adenocarcinoma had been made 5 years earlier.

The patient presented with a nodular, non-ulcerated, red lesion on the right eyebrow, which had developed approximately 6 months earlier. The lesion was firm and measured 0.7 cm at its largest diameter (Fig. 1). Cervical lymph nodes were not enlarged. Five years earlier, gastric adenocarcinoma had been diagnosed and partial gastrectomy with gastroenterostomy had been performed. Routine laboratory examinations revealed megaloblastic anaemia, and high serum levels of carcino antigen (CA) 19.9 were found (28.17 U/ml; normal: 1–15.8). Histologic examination of the cutaneous lesion showed the presence of an infiltrate located in the whole dermis to the subcutis. In some areas glandular structures could be observed. Atypical cells and mitotic figures were frequent (Fig. 2). Immunohistochemical investigation, performed with a standard 3-step immunoperoxidase technique on routinely fixed, paraffin-embedded tissue sections showed reactivity of the neoplastic cells for cytokeratin antibodies and negativity with anti-protein S-100, anti-leucocyte common antigen and HMB-45 antibodies. An esophagogastroscope was negative. Computed tomographic (CT) scans of the chest and abdomen were negative. Based on clinico-pathological findings a diagnosis of cutaneous metastasis of the eyebrow was made. The patient declined any therapy and is alive after a follow-up period of 4 months. Another two lesions on the eyebrow have recently occurred, and the patient has again declined treatment.

The most common clinical presentation of cutaneous metastasis is that of multiple nodules that appear suddenly in a specific area of the body, grow rapidly and then tend to remain stationary. Metastatic lesions are frequently localized in the region of the primary tumour or in surgical scars, rarely in distant sites. Cutaneous metastases from gastric adenocarcinoma usually occur in the abdominal wall or in the umbilicus (so-called sister Mary Joseph’s nodule). However, Gates (2) reported 3 cases metastasizing to the head, and Brownstein & Helwig (3) described cutaneous metastasis located to the face. In our experience, the most common sites are abdomen, umbilicus, trunk and face, in decreasing order (4). Recently, unusual sites including the lip (5) and phalanges (6) have also been documented. The frequency of skin metastases from stomach carcinoma seems to be quite low: Lookingbill et al. (7), in a review of 7,316 cancers, found no case of skin involvement from gastric carcinoma. According to the United States literature, this phenomenon is attributable to a declining incidence of this
cancer. Clinically, the solitary lesion in our patient appeared to be either a basal cell carcinoma or an adnexal tumour. However, histological and immunohistochemical features allowed the diagnosis to be established. Our patient presented with cutaneous metastasis 5 years after treatment of the primary tumour. However, skin metastases from stomach carcinoma rarely represent the first sign of malignancy (4).

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