It is well known that PV antigen is a 130 kD transmembranous desmosomal cadherin-type glycoprotein (desmoglein 3; Dsg3) (6,7), whereas PF sera react with the 160 kD PF antigen (desmoglein 1; Dsg1). There are very few reports concerning antigens with which P Veg sera react. Parodi et al. reported that serum of Neumann type of P Veg reacted with the 130 kD PV antigen, as well as a number of other proteins, with immunoprecipitation assay (3). We also reported that the sera of two cases of Hallopeau type of P Veg reacted with the 130 kD PV antigen with immunoblotting of human epidermal extract (8), although in addition these sera reacted with bovine desmocollin, another group of desmosomal cadherin. These results suggest that the PV antigen is target antigen for P Veg. However, since there are obvious differences between P Veg and PV, it is also possible that other antigen(s) may be involved in the pathogenesis of P Veg.

In the present study, the 130 kD protein detected by our patient's serum co-migrated with the PV antigen reacted by sera of typical PV patients. Although the possibility cannot be completely excluded that our patient's serum detected a different protein with the same molecular size as that of PV antigen in the one-dimensional gel, the strong and exclusive reactivity with the 130 kD protein clearly indicates that this serum reacted with the PV antigen. To the best of our knowledge, this is the first case of Neumann type of P Veg, shown to react with the PV antigen with immunoblotting of epidermal extracts.

The mechanisms by which PV and P Veg develop different clinical manifestations are still unknown, although these diseases show indistinguishable immunological findings. To understand the pathogenesis of P Veg, further examinations for more P Veg cases will be necessary, such as cytokines that induce epidermal proliferation and eosinophilic chemotaxis.

REFERENCES

Accepted September 27, 1995.

Yoshiyuki Ohata, Hiroko Komiya, Yoshie Kawahara, Kyoko Watanabe, Takeji Nishikawa and Takashi Hashimoto* Department of Dermatology, Keio University School of Medicine, 35 Shinanomachi, Shinjuku, Tokyo 160, Japan.
*Reprint requests.

Is EMLA Effective in Dercum’s disease?

Sir,

Adiposis dolorosa or Dercum’s disease (DD) is characterized by overgrowth of skin in some body areas with tenderness at first, then pain: the pain can be continuous or cyclic. It predominantly occurs in postmenopausal women with a tendency to fatness, fatigue and psychic disturbances; sometimes a dominant inheritance can be proved (1, 2). Histopathologically DD is indistinguishable from ordinary lipomas, normal fat cells like those of the subcutaneous tissue. Occasionally the histological appearance is that of an angiolipoma, or granulomas of the foreign body type have been noted within the fatty tissue (3). Right from the beginning there is tenderness, later followed by pain: it lasts for hours and worsens with movement, compelling the patient to immobility during attack.

CASE REPORT

The patient was a 50-year-old woman, a Catholic nun. Her medical history was uneventful apart from a surgical menopause caused by uterine fibromata at the age of 43. Since the age of 30 the patient had suffered from migraine treated with NSAIDS.

A limp and aching swelling, covered with a lightly erythematous skin, occurred on the patient's right hip; it was removed by a surgeon, without result. Four months later another swelling, similar to the first and symmetrically disposed, occurred on the left hip. Later on, analogous lesions developed on the shoulder girdles and arms. All examinations (laboratory tests, X-ray, echography, electromyogram) were normal.

A skin biopsy showed the histological picture of lipoma; electron microscopy, too, indicated no difference from the ultrastructural appearance of lipoma. This together with chemical features, their length, the patient's weight increase (from 52 to 60 kg) and psychic weakness that appeared during the stay in hospital led to the diagnosis of DD.

The following treatments were tried without any success: intravenous lidocaine, meclozine orally given and methylprednisolone i.m. Psychotherapy carried out in the same time was of no benefit. Liposuction was suggested: the patient, after carefully weighing up the benefits and risks, refused it.

A eutectic mixture of local anaesthetics (acronym EMLA) brought relief to the patient even if for just a short time. EMLA emulsion (Astra), applied under occlusion for half an hour (and afterwards washed away) only on those areas where pain was more severe (no more than 2,000 cm² in any case), secured the patient 3 h of analgesia.
EMLA produced this effect every time (almost daily) the cream was applied without lowering of analgesia time during the days of observation as inpatient.

The level of analgesia achieved after EMLA removal was enough for pin-prick anaesthesia. In the follow-up, 3 months later, the EMLA effect on our patient’s pain was unchanged. In this period EMLA was discontinued and a placebo cream was applied like EMLA for 10 days, during which the patient had no benefit: under pin-prick test the patient could determine where (right-left) EMLA-placebo had been applied.

DISCUSSION

The effectiveness of intravenous lidocaine in delaying the frequency of DD pain fits, as well as lowering it, has not been proved in our patient because of the adverse psychic side-effects (sexual dither, awkward especially for a nun, even after the infusion of 200 mg) that added to cardiocirculatory ones peculiar to the drug.

Cushing syndrome appeared shortly after the beginning of the treatment with corticosteroid, and the poor effectiveness of the treatment itself led to its interruption. Only application under occlusion of EMLA brought transitory (about 3 h) relief to the patient.

The risk of sensitization to prolonged application of a drug on the skin in a chronic disease, the width of the area under treatment and the following hazard of methaemoglobinemia (6, 7) meant that, in this particular case, use of this anaesthetic emulsion was restricted to the moments of maximum pain intensity.

REFERENCES


Accepted October 31, 1995.

M. Reggiani, A. Errani, M. Staffa and S. Schianchi
Dermatology Department, District Hospital, Via T. Masi, 3, I-48022 Lugo (RA), Italy.

Cutaneous Leishmaniasis: An Old Disease with a New Face

Sir,

There is a world-wide resurgence of interest in leishmaniasis both as an endemic disease of high morbidity in many countries of the Middle East and as an investigative tool of host-parasite interactions. The overall picture of the disease has been changing in several aspects. Indeed, new clinical patterns and novel discoveries on the vector front have expanded the spectrum of the disease and broadened its etiological basis.

Thus, a species like Leishmania tropica, long considered responsible for purely cutaneous disease, has recently been reported to cause visceral illness in veterans of operation “desert storm” (1).

In Lebanon and during the 15-year civil strife, the exodus of non-immunized citizens into rural areas and neighboring endemic countries across the Middle East accounts for the change noted over the past years in the clinical presentations and the concomitant histological manifestations.

We describe 3 patients in whom the clinical and histological features are underscored.

CASE REPORTS

Case 1
A 57-year-old man complained of two skin lesions located close to the outer canthus of the right eye, of 2 months' duration. Each was a 1-cm erythematous nodule with an atrophic center and pearly telangiectatic borders (Fig. 1).

Fig. 1. Acute cutaneous leishmaniasis simulating basal cell carcinoma.

Case 2
A 53-year-old man complained of erythematous infiltrated plaques with surface scaling and erosions over the elbows bilaterally (Fig. 2). The lesions were of 4 months' duration and were gradually increasing in size. The patient had travelled to Syria, an endemic country, prior to the onset of the skin lesions.

Acta Derm Venereol (Stockh) 76