Chronic *Giardia intestinalis* Infection Presenting with Clinical Features Mimicking Lichen Planus

Camilla Vassallo, MD¹, Valeria Brazzelli, MD¹, Sara Martinoli, MD¹, Marco Ardigò, MD¹, Michela Quaglini, MD¹, Massimo Scaglia, MD² and Giovanni Borroni, MD¹

¹Department of Dermatology and ²Laboratory of Clinical Parasitology, University of Pavia, Policlinico S. Matteo-IRCCS, Piazza Golgi 2, 27100 Pavia, Italy. E-mail: cvassallo@yahoo.com

Accepted May 11, 2001.

Sir,

Human giardiasis, caused by *Giardia intestinalis*, a flagellate protozoan parasite that colonizes the small bowel, is a worldwide infection (1). *Giardia* infection is usually asymptomatic but intestinal illness may occur (2–5). Several reports describe the association of allergy with increased levels of total serum IgE antibodies and of specific IgE antibodies against food allergens in patients affected by giardiasis, and *Giardia* infection may determine altered absorption of food antigens causing allergic sensitization (6). Cutaneous signs may be virtually indistinguishable from those of atopic dermatitis (7, 8). Acute reactions such as urticaria or asthma have also been described (9–11). We here report a patient affected by giardiasis, with lichen-planus-like lesions as the sole clinical feature.

CASE REPORT

A 64-year-old otherwise healthy woman was referred to the Department of Dermatology of the University of Pavia with an 8-month history of pruritic papular eruption, for which she had not taken any drugs. Physical examination revealed purplish, polygonal, flat-topped papules, with a tendency to confluence, localized on her wrists, abdomen, ankles and sacral region (Fig. 1). No mucosal involvement was present. A clinical diagnosis of lichen planus was suspected, and a 4-mm punch biopsy was performed. The histopathologic findings were characterized by superficial, deep perivascular dermatitis with a dense inflammatory infiltrate composed of lymphocytes, histiocytes and many eosinophils (Fig. 2). A number of eosinophils could also be observed between the collagen bundles. Tiny, spongiotic vesicles were focally present in the epidermis. Histopathologic findings led to a hypothesis of allergic dermatitis and further laboratory investigations were started.

Patch tests with standard contact allergens were negative. Total IgE antibodies as well as specific IgE antibodies against the most common antigens were all within the normal range. Complete blood count revealed a white blood cell count of $6 \times 10^9/l$ (normal range: $4.1–10.9 \times 10^9/l$) with 13.9% eosinophils. A parasitological stool examination revealed typical

Fig. 1. Violaceous papules with a polygonal outline and flat top that have become confluent in the midline.

Fig. 2. The histopathologic findings, namely, a superficial and deep perivascular dermatitis with many eosinophils and focal spongiosis, excluded a lichenoid dermatitis.
ovoid-shaped *Giardia* cysts. A one-day oral treatment with ornidazole (Tiberal®, Roche) at dosage of 1,500 mg, then repeated after 2 weeks, was given. The cutaneous lesions gradually improved after the first dose of the drug. After one month, however, new papules on elbows appeared and a coproparasitological control revealed the persistence of the parasitic infection. A new cycle of ornidazole (1,500 mg/day for 3 days) was prescribed. One month later both cutaneous lesions and *Giardia* cysts in stools were still present. An alternative treatment with oral paromomycin (Humatin®, Parke-Davis), 500 mg q.i.d for 5 days was prescribed. The cutaneous follow-up at 1, 3 and 6 months was negative and cutaneous signs and symptoms completely resolved.

**REFERENCES**


**A Patient with a Mucocutaneous Eruption and Intestinal Giardiasis**

K. Lammintausta 1, P. Kotilainen 2, U. Hohenthal 2 and L. Talve 3

Departments of 1Dermatology, 2Medicine and 3Pathology, Turku University Central Hospital, FIN-20520 Turku, Finland.

E-mail: kaija.lammintausta@tyks.fi

Accepted May 16, 2001.

**Sir,**

Acute neutrophilic dermatoses are a diagnostic challenge to clinicians and can sometimes mimic erythema nodosum (EN). Overlapping of the clinical dermatoses and their histopathology exists and the relationship between skin manifestations and potential etiologic factors may be indefinite. We describe here a case where the diagnosis of EN was established by biopsy and where intestinal giardiasis was recognized as a potential etiopathogenetic agent.

**CASE REPORT**

A 44-year-old woman presented with intermittent fever, up to 40°C, lasting 5 days and followed by painful skin nodules and pustules in association with stomatitis, painful vaginal erosions and arthralgia. The patient had been using contraceptive pills for about 3 years but was taking no other permanent medication. Neither had she any remarkable health problems, apart from a history of recurrent aphthous stomatitis, which recidivated one week before the present illness.

On examination, the patient appeared tired and sick. She complained about arthralgia in her knees. The lower legs were painful and swollen, with several inflamed, bright red, slightly raised nodules. The nodules (2 to 5 cm in diameter) also occurred on the arms, in the upper part of the body and in the genital mucosa. A central pustule was seen in some nodules and pustular lesions occurred diffusely in the skin. In the

*Acta Derm Venereol 81*