vesicular plaques on the glans. Physical examination also showed well-demarcated similar erosions, 2–3 cm in diameter, on the shaft.

The anamnesis revealed that during a business trip in the U.S.A. the patient had purchased "Nature's Bounty Natural melatonin" in order to prevent jet lag syndrome. These tablets contain 3 mg of melatonin and also magnesium stearatum, stearic acid and silica.

Furthermore, the anamnesis revealed that the patient used to take these pills at the dosage of one pill a day every time he went abroad and that he had experienced an episode similar to the one observed by us 4 months earlier.

In the same period we observed another businessman, 42 years of age, who presented a well-marginated, round, 4 cm in diameter, erosive plaque on the ventral surface of the shaft. In this case too fixed drug erythema developed after the beginning of a treatment with "Nature's Bounty Natural" for preventing jet lag.

In both patients we performed a peroral provocation test, consisting of administration of 1 mg of pure melatonin, supplied by our hospital pharmacy. The patients looked for any reaction over the next 24 h. Six to 8 h after taking the melatonin, plaques appeared in both patients in the previously affected sites, accompanied by a burning sensation. The lesions disappeared within 10 days without any sequelae.

Since the patients refused to perform an open test on the previously involved genitalia skin, melatonin powder in ethanol, at a concentration of 10%, was applied to normal skin of the back, and the patients were followed up for 24 h. In both patients the results were negative.

DISCUSSION

The clinical diagnosis of fixed drug eruption is usually easy. Although oral provocation is usually a safe method for in-patients, there is always, however, a potential risk of anaphylaxis or severe cutaneous reactions. Unfortunately, challenge testing with the suspected drug is still the only reliable method; in fact, attempts to demonstrate the specific causative agent with a patch test on the affected skin have so far been unsuccessful. When a patch test is performed at the site of such a lesion, if anatomically possible, a positive response occurs only in about 30% of patients.

In the U.S.A., melatonin is an over-the-counter drug, which can be found in any supermarket or drugstore. Even though both of our patients purchased the same brand of melatonin, we believe that this was most likely a coincidence.

In Europe many countries such as the U.K., Switzerland, France and now also Italy have blocked the uncontrolled sale of melatonin.

We are unaware of any other cases of fixed drug eruption due to melatonin in the literature. The widespread use of melatonin all over the world has led us to report these two cases, in order to inform physicians that this hormone too can be included among drugs responsible for fixed drug eruption. Intake of this drug should therefore be investigated in the anamnesis.

We believe, in fact, that in the future there will be many new cases of drug eruptions due to the use of melatonin, since it is the new fashionable drug and is easy to purchase, especially in the U.S.A.

REFERENCES

1. Webb SM, Puig-Domingo M. Role of melatonin in health and disease. Clin Endocrinol 1995; 42: 221–234.
2. Petrie K, Dawson AG, Thompson L, Brook R. A double blind trial of melatonin as a treatment for jet-lag in international cabin crew. Biol Psychiatry 1993; 33: 526–530.
3. Crabbe Erush S. The use of melatonin in the alleviation of jet-lag. Drug Inf Search 1994; 555–556, 561.
4. Dahlitz M, Alvarez B, Vignon S, et al. Delayed sleep phase syndrome response to melatonin. Lancet 1991; ii: 1121–1124.

Accepted June 11, 1997.

F. Bardazzi, F. Placucci, I. Neri, A. D'Antuono and A. Patrizi
Department of Dermatology, Bologna University, Via Massarenti,1, IT-40138 Bologna, Italy.

Rosacea Fulminans with Extrafacial Lesions

Sir,

Rosacea fulminans, previously called pyoderma faciale, is a rare conglobate, nodular disease reported to be restricted to the face, only occurring in women (1). The condition responds to topical and systemic corticosteroids, unlike ordinary rosacea. Here we present an unusal case conceived as rosacea fulminans with extensive extrafacial lesions.

CASE REPORT

The patient was a 35-year-old woman with rheumatoid arthritis, who had been treated with oral methotrexate 10 mg weekly for 2 months. She had no history of skin disease. In April 1995 she developed erythema and papulo-pustules on her left cheek. Her rheumatologist stopped the methotrexate treatment and gave her oral prednisolone, decreasing from 30 mg/daily to 5 mg/daily during the next 2 weeks. The lesions spread to the other cheek, with gradual aggravation of the eruptions. From the beginning of May she was treated with tetracycline 1 g daily for rosacea by a dermatologist. In the next 5 days she considerably worsened, with exudative exanthema, lesions on the trunk and fever, 38°C. At hospitalization in the Department of Dermatology her face and chest were covered by oozing crusts, erythema and papulo-pustles (Fig. 1A). The backs of her hands showed multiple papulo-pustules and erythema (Fig. 1B). There were fewer, but the same type of lesions on the flexor sides of both arms and on the thighs. The oral and the genital mucosa were unaffected. Treatment was started with saline-soaked dressings on the face. Triamcinolone acetonide cream was applied twice a day to her body. Acyclovir and dicloxacillin were given orally until negative microbiological tests were received and tetracycline was again started up. Prednisolone 5 mg daily was continued during hospitalization. The CRP and the sedimentation rate were raised and there was leukocytosis (27,700 WBC/mm^3) with neutrophilic granulocytosis (23,600 cells/mm^3). All the other laboratory investigations were within the normal range. PCR examinations were negative for both varicella zoster and herpes simplex. Bacteriological investigation of the content of the pustules was negative. Histopathological examination showed superficial pustular folliculitis and *Demodex folliculorum* were not seen. The temperature normalized and the eruptions began to remit after 2–3 weeks. When discharged, the patient had erythema and a few papulo-pustules in the face; she was still receiving

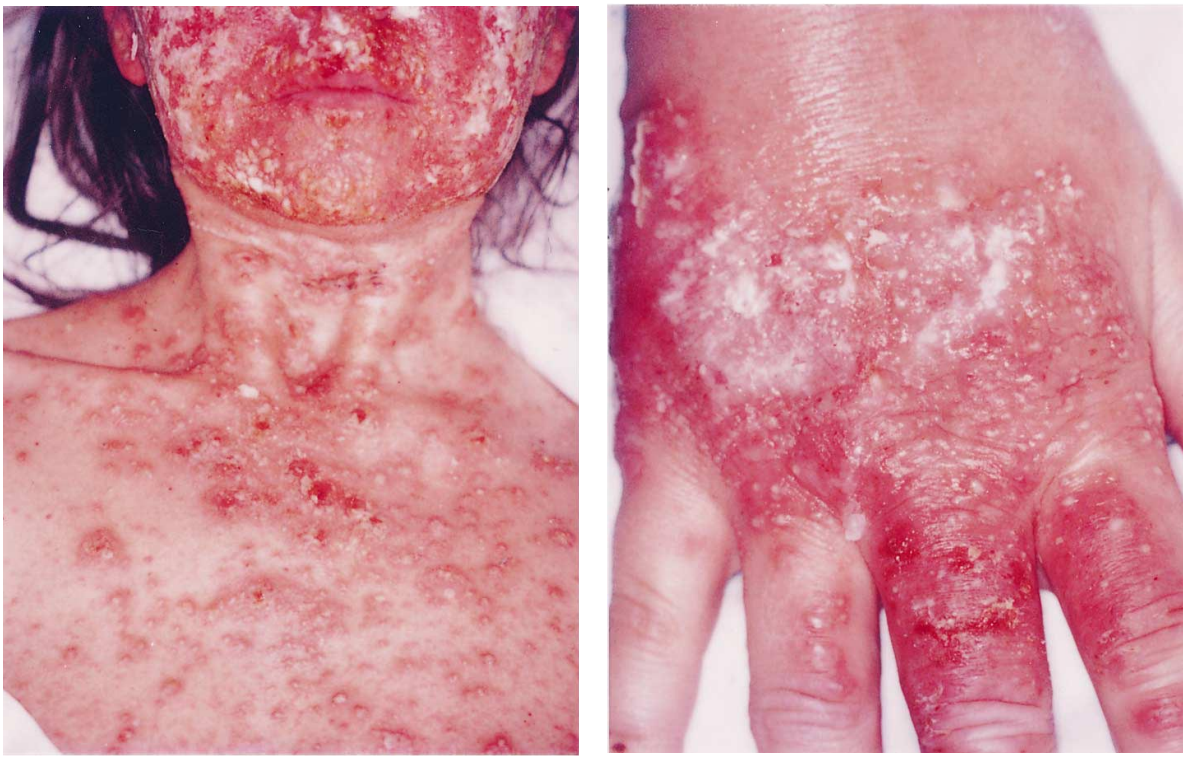

Fig. 1. The patient on admission. (A) Erythema and oozing crusts in the face and on the chest. (B) Papulo-pustles on the dorsal side of the hands.

5 mg prednisolone daily and was later followed up monthly at the out-patient clinic. Tetracyclin 1 g daily was continued for the next 3 months. When the patient got pregnant a few months later, she had a flare-up of her rosacea, but only in the facial area.

DISCUSSION

The patient described had extrafacial lesions, which usually points in the direction of acne fulminans. Plewig et al. (2) studied 20 patients with clinical rosacea fulminans and reported that extrafacial lesions were isolated and few, if present. But extrafacial lesions have been described by many authors in patients with ordinary rosacea. The patient described had no comedones, and she had facial erythema, telangiectasia and papules before and after the aggravation. The disease activity was probably too great for tetracycline to show any quickly improving effect the period before admission. Due to the possibility of infection, prednisolone was not increased at hospital admission. Huge leukocytosis (pseudoleukemoid reaction) is reported in other severe dermatoses, like acne fulminans and pustular psoriasis. A methotrexate drug eruption seems unlikely in the present case, since she had a new outburst of facial rosacea in the year after the hospital stay. It is, however, possible that methotrexate caused a flare-up of an "underlying" rosacea.

REFERENCES

1. Jansen T, Plewig G, Kligman AM. Diagnosis and treatment of rosacea fulminans. Dermatology 1994; 188: 251–254.
2. Plewig G, Jansen T, Kligman AM. Pyoderma faciale. A review and report of 20 additional cases: Is it rosacea? Arch Dermatol 1992; 128: 1611–1617.

Accepted July 25, 1997

Åse Haugstvedt and Jens Roar Bjerke
Department of Dermatology, Ullevål Hospital, NO-0407 Oslo, Norway.

Disseminated Morphea in Small Cell Lung Cancer

Sir,

A 34-year-old woman, non-smoker, presented with the complaints of cough and hemoptysis since 1 month. Physical examination and routine laboratory investigations were normal. In the chest radiograph and computerised tomography, a mass was observed in the right hilus, with mediastinal invasion. Neuron-specific enolase was elevated at 170 ng/ml (normal, 0–12.5). Bronchoscopy revealed a mass obliterating the lower lobe segment of the right main bronchus. The pathologic diagnosis was anaplastic small cell type lung cancer.