Erythroderma, Seborrheic Keratoses and Leser-Trélat Sign

Sir,

Schwengle & Rampen (1) in their recent article discuss the association of eruptive seborrheic keratoses in an erythrodermic condition and make incorrect inferences to the sign of Leser-Trélat. I hope I may be permitted to point out a number of fundamental misinterpretations in their manuscript, specifically concerning the sign of Leser-Trélat (2, 3).

Firstly, it is clearly delineated in my earlier manuscripts that this sign must be interpreted with caution in the face of chronic skin irration. It is well known that erythrodermic states can induce proliferation of seborrheic keratoses without any association of malignancy. Every example they list in their paper (1) concerning the occurrence of these lesions in the presence of skin irritation has already been discussed in *detail* in my earlier review (2). Thus, they present *no* new data which has hitherto not been previously examined carefully (2, 3).

Secondly, earlier publication by Schwengle et al. (4) of a supposed case control study of eruptive seborrheic keratoses and internal malignancies is refuted by myself in a forthcoming letter to the editor (5). Their study design and its conclusions have *no* foundations whatsoever as far as the sign of Leser-Trélat is concerned. I will not go into detail here but suggest interested persons consider reading the forthcoming letter (5).

Thirdly, these authors again suggest a parallel course of the seborrheic keratoses with the progression or regression of the tumor. This association simply does not hold up as I have repeatedly emphasized in the literature (2, 3, 6). Lastly, although of minor significance in this paper (1), a follow-up period of 6 months in *any* patient without evidence of an underlying tumor *never* reliably excludes the possibility that a malignancy will not occur at a later date (2, 3, 6).

In essence, these authors present a case of eruptive lesions occurring on irritated skin that must be interpreted with caution as far as the sign of Leser-Trélat is concerned. I have recently published the most stringent criteria for appropriate definition and evaluation of the sign. These authors would do well to read the literature more carefully such that they not will publish a third misrepresentation of data of the sign of Leser-Trélat.

I welcome any comments and suggestions from those who would care to correspond about this interesting dermatological manifestation.

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Response to Dr Mack R. Holdiness' Letter

We apologize for having already published a third fundamental misrepresentation of data related to the sign of Leser-Trélat (1). At the time we received the rebuttal of Dr Holdiness our manuscript had already entered the phase of proof-reading.

To the point! The controversy concerns a 74-year-old woman with a myriad of seborrheic keratoses of sudden appearance during the course of an erythrodermic skin condition (2). We counselled caution as to the interpretation of this finding. We agree with Dr Holdiness that the reported case should not be subsumed under the category of Leser-Trélat sign. We also agree that similar patients have been published before. Nowhere in our article did we claim that our observation has not been described by other authors. So far, we take the same view as Dr Holdiness. Why then filling expensive correspondence columns of medical journals with such a petty matter?

What is new in our case report is the possible role of retinoid therapy. Moreover, published cases of multiple seborrheic keratoses in association with erythrodermia are very rare. This certainly justifies an additional report, especially when accompanied by some critical remarks on the sign of Leser-Trélat. Here we come to the heart of the matter. Dr Holdiness is a warm champion of the Leser-Trélat sign (3). We are not (1).

After careful scrutiny of the literature we conclude

that most, if not all, observations of the Leser-Trélat sign are probably artifacts. This means that the alleged association must be due to coincidence. What should hold this paraneoplastic manifestation upright are the parallel course with the activity of the malignancy and the sudden appearance of the keratoses. It is disturbing to realize that Dr Holdiness seems to reject the parallel course of the keratoses and the progression or regression of the tumour as a *sine qua non* for the definition of the Leser-Trélat sign (3). Moreover, the "sudden" emergence of multiple keratoses or the "sudden" increase in number and size of pre-existing keratoses has little meaning in the elderly (1). Physical incapacity and mental disturbances preclude appropriate interpretation of skin signs.

We reiterate that the validity of the sign of Leser-Trélat must be questioned. Available literature data are lacunar and contradictory. Proponents of the sign base their conclusions merely on vague premises rather than on critical appraisal. The definition and evaluation of the Leser-Trélat sign is not served by expanding the list of case reports but large epidemiological studies. In this respect, our case control study on seborrheic keratoses and internal malignancies merits thorough consideration by Dr Holdiness and by all who are interested in the subject (4).

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Development of Metastatic Skin Cancer During Methotrexate Therapy for Psoriasis

Sir,

Immunosuppressive agents are increasingly being used in the treatment for non-fatal disorders. We report a case of metastasizing squamous cell carcinoma after treatment with low doses of methotrexate exclusively for 14 years.

An otherwise healthy 67-year-old man with a 40-year history of psoriasis had been treated for 14 years with 2.5 mg of methotrexate two to three times a week. He had never been treated with corticosteroids, arsenic or other immunosuppressive agents. In 1982 a cutaneous tumour was removed from the dorsum of his right hand with curettage. Microscopic examination revealed a highly differentiated squamous cell carcinoma, resembling a keratoacanthoma. The treatment was considered sufficient. There was no local recurrence, but in February 1987 he was admitted to the Department of Thoracic Surgery with a firm tumour, fixed to the thoracic wall just below the lateral part of the right clavicle. At operation the patient was considered inoperable because of local tumour spread. Only partial excision was undertaken. Microscopic examination disclosed a highly differentiated squamous cell carcinoma. Radiotherapy was given postoperatively. Later numbness and paresis of the right arm developed. In February 1988 ultrasonic scanning showed a solid process below the lateral part of the right clavicle. On CT scanning of the lungs and liver no metastases were observed. A further attempt to control the tumour by surgery was undertaken but failed. In consideration of the function of the upper extremity only partial resection of the tumour was judged possible. Microscopic examination now revealed a poorly differentiated squamous cell carcinoma. In August 1988 a cancerous ulcer appeared in the right clavicular region, with numerous subcutaneous nodules lateral to the ulcer and in the axilla. The patient had unbearable pain in his right arm, which was paralytic and useless. He was admitted to the Department of Plastic Surgery, where a palliative forequarter amputation was performed. After the amputation the general condition of the patient improved. Methotrexate was withdrawn and the patient was admitted to Department of Oncology for further treatment.

DISCUSSION

Squamous cell carcinoma in connection with psoriasis seems to be rare and has mostly been accounted