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

for by preceding arsenical therapy (1). There has been a previous report on a case of metastasizing squamous cell carcinoma during chronic immunosuppression by a combination of methotrexate and corticosteroids (2). Methotrexate in small doses is a useful agent in the treatment of severe psoriasis, but is also a potent immunosuppressive drug. It is known that depressed immunity may be associated with an increased risk of development of skin cancer (3). Additional cases need to be reported before any causal relationship between methotrexate and metastasizing squamous cell carcinoma can be assumed. However, we consider that the history of our patient indicates: 1) that methotrexate medication should, when possible, be withdrawn when a localized squamous cell carcinoma is diagnosed, and 2) that when such a diagnosis is confirmed, the patient should be referred for lege artis radical treatment, whether surgical or radiotherapeutic.

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2. Harris CC. Malignancy during methotrexate and steroid therapy for psoriasis. Arch Derm 1954; 160: 501–504.
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ANNOUNCEMENTS

25th Nordic Dermatological Congress will be held in Copenhagen 11–14 June, 1989. Congress language: Scandinavian. For information Congress secretary Jytte Roed-Petersen, Department of Dermatology, Amtssygehuset i Gentofte, DK-2900 Hellerup, Denmark. Telephone number 45-1-651200.

The first Gordon Research Conference on *Barier Function of Mammalian Skin* will be held at the Brewster Academy, Wolfborough, NH, on August 14–18, 1989. For information: Dr. Alexander M. Cruickshank, Gordon Research Center, University of Rhode Island, Kingston, Rhode Island 02881-0801.

4th Steglitz Pediatric Surgical Symposium Berlin Laser Application in Children. November 10–11, 1989. For information. Priv. Doz. Dr Felix Schier, Department of Pediatric Surgery, Hindenburgdamm 30, 1000 Berlin 45, West Germany.

35th General Assembly of the International Union against Venereal Diseass and the Treponematoses will be held on 9–11 May, 1990 at the Royal Society of Medicine, London on the subject of "Sexually transmitted diseases in the age of AIDS". For information: Barbara Komoniewska BA. The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE.

The Third Congress of European Society of Pediatric Dermatology will be held in Bordeaux, September 21–23, 1990. For information: Service de Dermatologie Pédiatrique, Hôpital des Enfants, 168, cours de l'Argonne, F-33077 Bordeaux Cedex, France.

Graduate Program in Dermatology 1989–1990. Thomas Jefferson University, Philadelphia, Pennsylvania. 1. Graduate studies in dermatology. 2. Continuing medical education courses. 3. Fellow-ships. 4. Enrichment programs for allied health professionals. For information: Jefferson Center for International Dermatology, Department of Dermatology, Jefferson Medical College, 1020 Locust Street, M46, Philadelphia, PA 19107, Tel: (215) 928-5785.

BOOKS RECEIVED

Advances in Dermatology edited by J. P. Callen, M. V. Dahl, L. E. Golitz, L. A. Schachner, S. J. Stegman. Vol 4, 1989, 374 pages, 29 Tables, 112 Figures. ISSN 0882-0880. Hard cover. Price £37.30. Year Book Medical Publishers, Inc., Chicago. Well-written articles on clinically relevant problems including cyclosporin A for skin diseases, sport-related skin injuries, pyoderma gangrenosum, condemia pemphigus, calcium as a second messenger, dermatitis in food handlers, pediatric skin diseases, vascular neoplasm, lyme diseases, keratinocyte differentiation, alopecia and dermatologic surgery. Valuable references. An editorial comment follows each article.

Year Book of Dermatology 1988 edited by Arthur J. Sober and Thomas B. Fitzpatrick, 1988, 466 pages, 65 Figures and 15 Tables. Hard cover. ISBN 0-8151-2674-3. Price £37.30. Year Book Medical Publishers, Inc., Chicago, London, Boca Raton.

Color atlas of AIDS edited by A. E. Friedman-Kien, 1989, 155 pages, 121 colour pictures. Hard cover. ISBN 0-7216-2759-5. Price £25.00. W. B. Saunders Company. Harcourt Brace Jovanovich, Inc. Philadelphia.

Contact Dermatitis in India edited by J. S. Pasricha. Second Edition, 1988, 155 pages, 51 colour pictures. Paper back. The Offsetters, 1880 Udaichand Marg, Kotla Mubarakpur, New Delhi-110003.