Papuloerythroderma Disease or Pattern?

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This journal published in 1984 the first paper of Ofuji et al. on 4 Japanese patients with a dermatosis 'beginning with solid papules and developing into erythroderma-like lesions' [1]. Dr. Ofuji insisted upon the sparing of flexural regions and the major transverse abdominal fold. This feature was subsequently described as the 'deck chair sign' by the dermatologists of Westminster Hospital in London 'to their St. John's Hospital colleagues' [2]. Several similar case reports have appeared in the literature since 1989 (see the reference list of the three papers on papuloerythroderma that appear in this issue of Dermatology [3-5].

What is the need for simultaneously publishing three further cases?

One is to outline that papuloerythroderma is neither exceptional nor confined to Japan.

Another is to understand how dermatologists from different countries in Europe have reached the diagnosis of papuloerythroderma; it is clear that the diagnosis was made upon clinical criteria, due to the distinct distribution pattern of the eruption; the pictures shown in the three reports in this issue are indeed very similar. This indicates that clinical dermatology has still a future; good clinicians, like Dr.

Ofuji, may still recognize and describe significant signs and patterns that had been previously ignored or considered as of no significance.

Finally, it is of interest to question the practical interest of making a diagnosis of papuloerythroderma.

The question remains whether this distinctive clinical situation corresponds to a specific pathological process ('a disease') or actually reflects a pattern of expression that many inflammatory dermatoses may take. That papuloerythroderma may be a 'prelymphomatous state' is likely and well discussed in the papers in this issue. It may well be that other etiologies such as hypersensitivity to drugs and contact allergy account for some cases; none of the features of papuloerythroderma is incompatible with such etiologies. In that respect, it is of interest that in most of the already published reports an in-depth search for such inducing factors has not been performed. It would be detrimental to the patient if, once the diagnosis of papuloerythroderma is established on clinical grounds, no further search for rather simple causes were done and systemic steroids were given. If so, describing new patterns of inflammatory dermatoses should not be considered as a progress.

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\$ 2.75/0