Flagellate Dermatitis after Bleomycin

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Sir,

We have read with interest the paper by Cortina et al. [1]. We observed a similar case [2] in which we performed a histological and immunohistochemical study [3]. Our histological findings were quite similar to those described by Cortina et al. [1], but we were not able to find any anaplastic-like cells or any atypical mitotic figures in the inflammatory infiltrates. Our immunohistochemical study showed that the infiltrates were composed mainly by T helper lymphocytes (ratio CD4/CD8 3:1). Thus, a strong HLA-DR expression against a mild positivity for interleukin-2 and a high degree of CD1-positive cells was noted in the inflammatory infiltrates. The low degree of interleukin-2 we found can be explained

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by the delay in observing the patient (10 days after the skin eruption) and in collecting the skin sample.

In conclusion, we believe that many of the CD1-positive cells detected are Langerhans cells. This appears to support the hypothesis of an antigenic stimulation exerted by the drug or its metabolites.

Moreover, in our case a specific infiltration of Hodgkin's disease was not detectable in the specimen from a linear lesion taken during the late inflammatory stage. This would contradict the occurrence of an inflammatory oncotaxis phenomenon during the erythematous phase of the flagellate dermatitis, as described by Cortina et al. [1].

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patient improved dramatically for the next month, and the danazol dose was reduced to 100 mg/day. No cutaneous lesions appeared during the next 4 months. Danazol was then interrupted because of hirsutism and gain of weight. Two months later, no new lesions have appeared.

Discussion

A hormonal influence is strongly suggested on the clinical expression of lupus erythematosus.

Moreover, some female patients may present premenstrual exacerbations of the disease [1].

Danazol, a heterocyclic steroid related chemically to 17 α -ethinyltestosterone, has been effective

in the treatment of systemic lupus erythematosus with premenstrual exacerbations [2], Good results have been obtained with 19-nortestosterone in 5 of 10 patients with systemic lupus erythematosus [3]. To our knowledge, premenstrual exacerbations of discoid lupus have been successfully treated with danazol only in 1 patient [4]. Clearly, double-blind studies are needed to clarify the therapeutic potential of danazol in discoid lupus.

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Danazol and Discoid Lupus Erythematosus

A 20-year-old woman presented erythematous hyperkeratotic, slightly atrophic plaques in both malar areas. She had no history of fever, malaise, oral ulcers, photosensitivity, arthralgia, chest pain or Raynaud's phenomenon. Physical examination was otherwise unremarkable. Erythrocyte sedimentation rate, complete blood cell count, urinalysis, hepatic enzymes, serum creatinine, immunoglobulins, anti-nuclear antibody. anti-DNA and antiextractable nuclear antigen were normal or negative. A skin biopsy specimen showed features consistent with discoid lupus. Direct immunofluorescence revealed a deposition of immunoglobulins in the dermal-epidermal zone, but these deposits were not present in nonlesional, nonexposed skin. The patient was initially treated with topical corticosteroids, but due to the persistence and apparition of new lesions, a course of hydroxychloroquine was begun. Despite this treatment, she referred premenstrual exacerbation of lesions. Danazol was then instituted (100 mg twice a day orally), and topical corticosteroids and hydroxychloroquine were interrupted. The

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