It has been assessed that the primary defect is not suitable for complete side-to-side closure. It allows the recovery of free tissue as a rotation flap that would otherwise be discarded as a dog-ear. Cosmetic and functional results have been highly satisfactory in all cases, as an excellent match in skin colour and texture has always been maintained. This surgical procedure has produced minimal tension across the wound edges, with less scarring and little or no distortion of adjacent anatomic structures. Though mainly applied on the head, the flap has been successfully performed on any anatomic location. According to our experience the comet flap can be a valuable surgical option for closure of round to oval defects of any size in dermatological surgery reconstruction.

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Therapeutic use of mistletoe for CD30+ cutaneous lymphoproliferative disorder/lymphomatoid papulosis

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Editor
Lymphomatoid papulosis (LyP) is defined in the WHO classification as a CD30+ cutaneous lymphoproliferative lymphoma (CLPD) and is regarded as a condition of...
An 8-year-old boy presented with reddish nodules (maximum of 7 cm in diameter) on his right forearm and left leg. Immunohistochemical analysis identified a CD30+ large, T-cell type non-Hodgkin’s lymphoma of the skin. Topical steroids were effective but 6 months later the patient developed axillary lymph-node swelling. Classifying the condition now as ALCL without signs of systemic involvement, combination chemotherapy according to the German ALCL trial (high-risk group) was given for 6 months. All nodules (cutaneous and lymphoid/axilla) resolved within a few weeks. However, 2 months after cessation of chemotherapy a new skin nodule on the left forearm appeared. No specific therapy was given. In the following 2 months the patient developed two further solid and painful skin lesions. We started subcutaneous therapy with Abnoba Viscum fraxini® (ABNOBA Heilmittel GmbH, Pforzheim, Germany) a mistletoe extract (MT). A schedule of two injections per week was initiated, starting with a dose of 20 mg in the first week, but choosing the subsequent exact dosages with a view to obtaining a marked local reaction with mild fever and local swelling. MT was injected subcutaneously close to the largest lesions. One day following the first local injection of MT, a fever of 38 °C was observed, plus local swelling and redness. The skin nodules started to decrease and MT injections into all lesions were continued. Within the following 2 weeks the skin lesions resolved. After regression of all local symptoms, subcutaneous MT therapy with two injections of 0.2 mg per week was continued.

Two months later, the patient developed two new small nodules that responded within a few days to an increased dose of MT. During 2 years of follow-up therapy with MT the boy remained without clinical signs of either LvP or ALCL. After 2 years, MT therapy was stopped. Unfortunately, 3 weeks after cessation of MT therapy the patient developed a relapse, displaying generalized reactivation of the cutaneous LyP with typical nodules (maximum 1 cm in diameter) all over the body. Subcutaneous and local intrallesional MT therapy was resumed and the cutaneous LyP regressed completely within 2 weeks without additional therapy.

It is known that CD30+ CLPDs have an overall excellent outcome. In our patient, initial topical MT therapy of LyP and subsequent systemic combination chemotherapy of ALCL were effective. As seen in our patient, relapse of LyP skin lesions is common. The good response of the second relapse of LyP to MT is suggestive but could also represent the natural history of LyP. After the third cutaneous relapse of LyP and the subsequent positive response to MT the therapeutic efficacy of MT in this patient seems evident. In particular, the temporal association between the MT injections and the response and the typical local reaction to MT are indications of a connection in this case. MT is widely used in Europe as an additional therapy for cancer patients and no adverse or long-term effects have been reported.

References

Scleredema adultorum associated with type 2 diabetes mellitus: a report of three cases

Scleredema adultorum is a rare disease of unknown aetiology that can be associated with type 2 diabetes mellitus. Therapeutic options are limited, but successful treatment with ultraviolet A1 (UVA-1) or antibiotics has been described.

Here, we report three cases of type 2 diabetes-associated scleredema.

The first patient, a 55-year-old Caucasian man presented with a 2-year history of thickening of the skin resulting in reduced mobility of the neck and shoulders, without systemic manifestations. He was treated with systemic psoralen and UVA (PUVA) followed by UVA-1 therapy, without success, 2 years ago.

The patient was again treated with UVA-1 (90 J/cm²) five times per week and by physiotherapy, resulting in softening of the skin and enhanced mobility within 4 weeks of initiation of treatment.

The second patient, a 57-year-old Caucasian woman had a 20-year history of thickening of the skin of the nape of the neck, trunk, upper arms, back and dorsal thighs. Mobility of the neck and shoulders was decreased. She was treated with UVA-1 several times without success. The patient was retreated with UVA-1 50 J/cm² on the whole body and additional 40 J/cm² on the nape of the neck and back. She suffered from sinusitis which was treated with intravenous clindamycin (3 × 600 mg/day) for 2 weeks because she was allergic to penicillin. The patient responded slightly with decrease of skin rigidity within 4 weeks after initiation of treatment.

The third patient, a 58-year-old Arab woman presented with thickening of the skin resulting in reduced mobility of her mimic muscles, neck and shoulders starting only about 2 months prior to admission to our clinic. Facial involvement resulted in a mask-like expression of the face (fig. 1). Mobility of arms and neck was also significantly reduced. The patient denied any previous infection. Histopathology was typical for scleredema, with mucin interposed between thickened collagen bundles, which was shown by colloidal iron staining (fig. 2).4,8,9 The same histological findings were detected in specimens from the other two patients. Because of the short history of her disease the patient was treated with intravenous penicillin (3 × 5 million U/day) for 2 weeks despite the absence of clinical signs of infection. Two months later the patient presented with remarkable improvement. Softening of the skin as well as increased mobility (especially of facial muscles and arms) had taken place; therefore, a scheduled UVA-1 treatment was not initiated.

Scleredema adultorum is a rare disease of unknown aetiology, which was first described by Buschke in 1900.3 It is characterized by non-pitting induration of the skin, with no defined boundary between normal and diseased skin and symmetric induration of the face, neck and nape. This can spread to the upper trunk and upper arms, or, more rarely, to other body regions. Moreover, multiple organs can be involved with respective complications. Skin