Annually recurring erythema annulare centrifugum: A distinct entity?

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Four patients presenting a peculiar clinical variant of erythema annulare centrifugum are reported. The lesions were clinically and histopathologically indistinguishable from classic superficial erythema annulare centrifugum but constant annual and seasonal recurrences for many years or decades were observed. No clear precipitating factor could be identified. No associated symptoms were present and the eruption regressed spontaneously after a variable period of days to months. Annually recurring erythema annulare centrifugum seems to represent a rare distinct clinical entity that has received little attention in literature. Clinicopathologic features of this peculiar clinical disorder and the differential diagnosis with other recurrent seasonal eruptions are reviewed. (J Am Acad Dermatol 2006;54:1091-5.)

A peculiar form of superficial erythema annulare centrifugum (EAC) presenting constant yearly recurrences for many years was first reported by Christine in 1930.[1] This peculiar variant of annually recurring (AR) EAC received little attention in the literature, and only isolated reports in the European literature[1] were published afterward. In 1986, Yoshikuni et al,[2] pointed out the possible association between AR EAC and hereditary lactate dehydrogenase (LDH) M-subunit deficiency.

We review the clinical, histopathologic, and biochemical features of 4 patients presenting with this peculiar and recurrent form of EAC.

Abbreviations used:

AR: annually recurring
EAC: erythema annulare centrifugum
LDH: lactate dehydrogenase

CASE REPORTS

Case 1

A 76-year-old woman was referred for evaluation of a relapsing self-healing annular eruption involving her trunk and extremities that had recurred yearly for the last 8 years. Medical history included diabetes mellitus, hyperthyroidism, valvular heart disease, cholecystectomy, and breast carcinoma (October 2000) treated with operation and chemotherapy. She was following treatment with acenocoumarol, glibenclamide, hydrochlorothiazide, and diltiazem chlorhydrate.

The patient presented annually relapsing nonpruritic annular lesions located on her chest, back, arms, and legs that constantly appeared in the summer and resolved spontaneously in autumn. The eruption began as small erythematous papules that coalesced into annular plaques with central clearing and centrifugal spread. No precipitating factors were identified. No fever, general symptoms, or mucosal lesions were present.

Physical examination revealed an apparently healthy woman with multiple 2- to 8-cm erythematous urticariform and annular lesions on her chest, back, arms, and thighs (Fig 1). A peripheral scaling border was occasionally noted. The lesions regressed spontaneously 4 months after onset. Neither inguinal nor axillary lymph nodes were present.

Case 2

An 83-year-old man was referred to our department for evaluation of a 23-year history of an AR pruritic annular eruption that appeared constantly during the summer months (May-June) and regressed spontaneously in autumn (September-October).

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Funding sources: None.
Conflicts of interest: None identified.

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0190-9622/$32.00

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doi:10.1016/j.jaad.2006.01.025

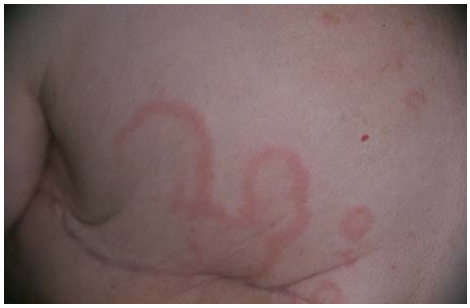

Fig 1. Erythematous urticariform and annular plaques on chest (case 1).

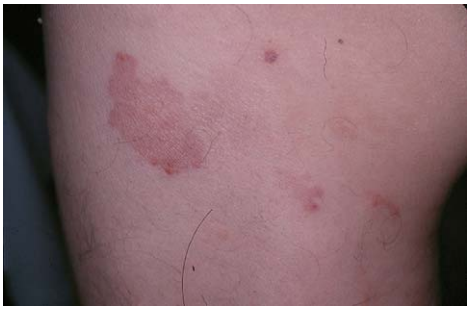

Fig 2. Erythematous purpuric infiltrated plaque on back aspect of thigh (case 2).

Medical history disclosed arterial hypertension and squamous cell carcinoma of the tongue diagnosed in 1988 treated with operation, radiotherapy, and chemotherapy in 1990.

During the last 5 years, physical examination had revealed multiple erythematous, purpuric infiltrated papules and plaques with centrifugal extension and central clearing that led to urticarial, nonscaly plaques with arcuate or annular elevated borders and central patchy hyperpigmentation. The lesions involved symmetrically the internal aspects of both arms and legs (Fig 2).

Case 3

A 55-year-old man came to our department for evaluation of a peculiar recurrent summer eruption. Medical history was unremarkable.

For the last 13 years he referred to the development of a peculiar and constant skin eruption in summer. No other precipitating factors were identified. The lesions were pruritic, erythematous, and violaceous annular plaques involving both legs and arms. They progressed centrifugally with fine peripheral scaling, persisted for 15 days and tended to disappear spontaneously. During the last 4 years the disorder was partially controlled with systemic steroid therapy. No mucosal lesions were present and the rest of the physical examination disclosed no abnormalities.

Case 4

A 55-year-old woman presented a 15-year history of recurrent symmetric violaceous purpuric annular erythematous plaques showing a central clearing and peripheral spread on her arms and legs. Medical history disclosed a goiter treated with surgical excision. The patient was treated with thyroidal substitutive treatment.

The eruption appeared in the spring and/or summer months and regressed spontaneously after 4 months. Physical examination revealed an apparently healthy patient with multiple annular papules and plaques on both arms and legs. The lesions were occasionally purpuric and painful, presented an active border, and progressed centrifugally with a discrete scaly peripheral rim and leaving occasional residual hyperpigmentation. The rest of the physical examination was unremarkable.

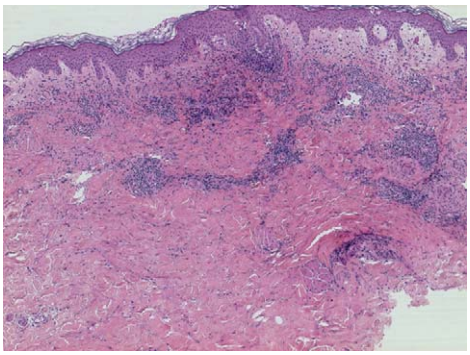

Fig 3. Edema of papillary dermis and moderated perivascular lymphocytic infiltrate in papillary and middermis (case 2). (Hematoxylin-eosin stain; original magnification: ×20.)

Laboratory studies

In all 4 patients a complete routine laboratory investigation including hematologic, biochemical (glucose, hepatic and renal parameters, serum electrophoresis), and immunologic (antinuclear factor, rheumatoid factor, A [Ro]/[La], organ-specific antibodies, immunoglobulins, radioallergosorbent) tests disclosed no abnormalities. *Borrelia burgdorferi* antibodies were constantly negative. Direct potassium hydroxide examination and cultures for fungi and bacteria from skin lesions failed to identify micro-organisms. No phototests were performed. Chest radiographs were consistently normal. Electrophoretic analysis of erythrocyte LDH isozymes was not performed (not available in our laboratory).

Histopathologic examination

Histologic examination of 5 skin biopsy specimens revealed an inflammatory perivascular lymphohistiocytic infiltrate of variable intensity in the papillary and middermis with occasional eosinophils

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