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CASE REPORT

Erysipelas of the upper extremity following locoregional therapy for breast cancer

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Summary Cellulitis is a well-known complication of lymphedema of the lower extremities. Erysipelas of the upper extremity complicating breast cancer therapy has never been reported in the English-language literature. We describe seven breast cancer patients with erysipelas of the upper extremity. Five had a predisposing injury to the extremity. All patients responded very well to intravenous antibiotics without any sequelae. They had rapid resolution with typical desquamation. No long-term sequelae were seen except for mild increase of lymphedema. Erysipelas should be listed as a rare complication after locoregional therapy for breast cancer. Intravenous penicillin should be used as the initial therapy. Prevention of arm lymphedema and avoidance of any trauma to the arm are important prophylactic measures. Sentinel lymph node biopsy reduces the rate of axillary lymph node dissection and thus should reduce the incidence of lymphedema and erysipelas.
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Introduction

Cellulitis is a well-known complication of lymphedema of the lower extremities. It is usually caused by streptococci group A, C, or G in association with chronic venous stasis or with saphenous venectomy for coronary artery bypass surgery. Streptococci also cause recurrent cellulitis among patients with chronic lymphedema resulting from elephantiasis, lymph node dissection, or Milroy's disease.[1] Erysipelas of the upper extremity following breast cancer treatment has never been reported in the English-language literature. It was vaguely described as a complication in a German-language journal[2] and as a case report in a Dutch-language journal.[3] In a French-language Tunisian medical journal in 2002,[4] erysipelas was described in 20 out of 700 breast cancer patients seen over 6 years,

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with a 20% recurrence rate, and 40% had local trauma as a predisposing injury; however, only 40% had redness, 35% had fever, and 20% had edema.[4]

Erysipelas (from the Greek: erythros ''red''+pella ''skin'') is also known as St. Anthony's Fire. It is an acute bacterial infection of the skin.[5] It is a sudden illness that presents with painful areas of erythema that enlarge with well-defined margins. It is generally associated with high-grade fever,[6] and erysipelas is often caused by group A β-hemolytic streptococci. Serology is often not performed since most cases are assumed to be caused by this pathogen. It is usually diagnosed from the characteristic clinical appearance of the rash. Blood cultures are positive in a minority of patients (5% in one series).[3]

In this article, we describe the first English-language report of seven patients with erysipelas of the upper extremity who had previously had locoregional therapy for breast cancer, out of a total of 310 patients seen by the corresponding author over 5 years.

Clinical cases

Case 1

A 53-year-old woman had a history of left breast cancer diagnosed in 2000 and treated with modified radical mastectomy (MRM) with axillary lymph node dissection, chemotherapy, and radiation to her left axilla and chest wall. She presented to our Emergency Department (ED) in February 2004 complaining of swelling, redness, and pain in her left arm of one day's duration. She had a fever of 39.5 °C. Upon examination she had swelling, warmth, tenderness, and raised, red, demarcated borders of the left upper extremity. She was treated with intravenous penicillin. Clindamycin was added after 24 h. Typical desquamation was noted after the third day. She was discharged on oral penicillin V and clindamycin for 10 days. She had had a similar episode of erysipelas of the left arm in June 2003 and had been treated with oral cephalothin.

The clinical characteristics of this patient and those described below are summarized in Table 1.

Case 2

A 55-year-old woman with a history of left breast cancer diagnosed in 1999 that was treated with MRM and axillary dissection, adjuvant chemotherapy, and radiotherapy, and a right breast cancer treated similarly in 1995. She presented to our ED in July 2000 with a 1-day history of fever, left upper extremity pain, swelling, and redness. She reported having had an insect bite to the left index 2 days prior to presentation. Her left arm was tender, swollen with demarcated erythema. She was treated with intravenous cephazolin. After 5 days she became afebrile and the area of erythema decreased. She was discharged on oral penicillin V for 14 days. In May 2002, she had a recurrent episode of erysipelas in the same arm with swelling, pain, redness, and high-grade fever. She was again treated with intravenous cephazolin and recovered fully.

Case 3

A 41-year-old woman with a history of right breast cancer diagnosed in 2002 and treated with quadrantectomy, axillary lymph node dissection, adjuvant chemotherapy, and radiotherapy, presented to our ED on December 2003 with right arm pain of a few hours' duration. She denied any fever or chills, but reported right arm swelling that had increased recently. She was noted to have a scar from a sharp object trauma to her second right finger. Her arm was warm and erythematous (Fig. 1). She was treated with intravenous penicillin and clindamycin. Erysipelas resolved gradually with desquamation (Fig. 2) and the patient was discharged home after 8 days on oral penicillin V and clindamycin for 1 week. She had no recurrent episodes and developed mild upper extremity lymphedema afterward.

Case 4

A 57-year-old woman with a history of recurrent right breast cancer with bone metastasis who was treated in 1995 with partial mastectomy, axillary dissection, radiotherapy, and chemotherapy, presented in October 2001 with one episode of chills, right arm swelling, pain, and erythema of 3 days' duration. She received intravenous penicillin. She improved and was discharged home after 3 days on oral Augmentin for 1 week.

Case 5

A 75-year-old woman with a history of left breast cancer diagnosed in November 2003 was treated with MRM with axillary dissection and hormonal therapy. In May 2004, she had an injury to the left forearm, which caused mild lymphedema. Ten days later she had swelling and redness of the left arm as

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