Exfoliative Dermatitis and Malignant Melanoma: Coincidence or Association?

To the Editor:
A 60-year-old man presented with exfoliative dermatitis of 3-months duration. It started as a contact irritant dermatitis involving both hands from an acid used for cleaning jewellery. Subsequently, the dermatitis became generalized. A provisional diagnosis of contact irritant dermatitis progressing to exfoliative dermatitis was made and prednisolone, 30 mg daily, was started after routine investigations. When his condition did not improve and the pruritus became intractable, the dose of prednisolone was increased to 60 mg daily, but pruritus and erythema continued to progress further. The diagnosis was then reviewed and a small lymph node from the left axilla was subjected to fine-needle aspiration cytology followed by biopsy. The histopathologic examination revealed metastatic malignant melanoma. There was no other lymph node enlargement. A thorough search for the primary growth including examination of skin, mucosae, and eyes, a roentgenologic survey of chest and bones, ultrasonography of abdominal viscera, and barium contrast studies of the gastrointestinal tract failed to reveal any primary focus. A whole-body computer tomography (CT) scan revealed slight thickening of the stomach wall and one enlarged para-aortic lymph node; however, on endoscopic examination, the suspicious area of the stomach showed a normal mucosal pattern and the biopsies taken from multiple sites revealed a normal histologic appearance. The patient was finally treated with vincristine and cyclophosphamide, with a diagnosis of metastatic malignant melanoma with occult primary. In 2 months of follow-up, the patient's general condition has deteriorated further and exfoliative dermatitis and pruritus have not shown any improvement.

Discussion
Exfoliative dermatitis has a varied etiology. It may be a cutaneous marker of malignancies, especially of lympho-reticular tissue.1 To the best of our knowledge, an association with malignant melanoma has not been documented.2 3 In our case, although the onset of exfoliative dermatitis was preceded by contact irritant dermatitis, its recalcitrant nature, despite an absence of other precipitating factors and treatment with systemic steroids suggests that it was a cutaneous marker of malignant melanoma. The role of contact irritant dermatitis in initiating exfoliative dermatitis was probably nothing more than a coincidental triggering factor.

Drug Names
Cyclophosphamide: Cytoxan
Vincristine sulfate: Oncovin, Vincares PFS

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References

Intralesional Chloroquine for the Treatment of Cutaneous Sarcoïdosis

To the Editor:
Sarcoïdosis is a multisystem disease with cutaneous involvement in 30% of cases. Cutaneous sarcoïdosis often involves the face and can cause significant disfigurement. When the disease is restricted to the skin, localized forms of therapy are utilized to avoid the morbidity associated with systemic treatment. Intralesional steroids have been the mainstay of treatment; however, their efficacy varies and the risk of atrophy and hypopigmentation sometimes limit their use.

Antimalarials have been used orally for the cutaneous lesions of sarcoïdosis since 1953. 12 The intralesional use of chloroquine was first reported by Everett and Coffey in 1961. 3 They treated three patients (two with discoid lupus erythematosus (LE) and one with lichen sclerosis et atrophicus) with chloroquine, 50 mg per mL with clearing of plaques. We report the use of intralesional chloroquine to treat lesions of cutaneous sarcoïdosis.
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