

REFERENCES

1. Reed, R. J., Glvaneck, E. & Lubrik, R. R.: Bullous congenital ichthyosiform hyperkeratosis. *Arch Dermatol* 89: 665-674, 1964.
2. Solomon, L. M., Fetzin, D. F. & Dewald, R. L.: The epidermal naevus syndrome. *Arch Dermatol* 97: 273-285, 1968.
3. Swint, R. B. & Klaus, S. N.: Malignant degeneration of an epithelial naevus. *Arch Dermatol* 101: 56-58, 1970.

Clinical
and Histopathologic Morphea
with Immunological Evidence
of Lupus Erythematosus:
A Case Report

Nils Jørgen Mørk

*Department of Dermatology, The National Hospital,
University of Oslo, Oslo 1, Norway*

Abstract. A 14-year-old girl developed skin changes after BCG vaccination. The clinical and histopathological findings revealed morphea. The immunofluorescence microscopy showed IgG, IgM, IgA, C3 and fibrinogen deposits at the dermal-epidermal junction area in both involved and uninvolved skin. The antinuclear antibody tests were all negative.

CASE REPORT

The patient was a 14-year-old girl who had allergic rhinitis. She had taken her BCG vaccination on her left shoulder in February 1979 and some weeks later she discovered some hypopigmented areas on the left shoulder and the left arm. She entered the hospital in March 1980. On examination we noticed several brown coloured patches and in the centre of these patches the skin was indurated and the colour was yellow to white. The patches were situated on the left side of thorax, her left shoulder and the left arm and hand, and they varied in size from about 1 cm to about 4 cm. The girl did not have other symptoms except her exanthema.

Immunologic investigations

ANA test, Waaler-Latex test, LE cell preparation, anti-RNP, anti-Sm and anti-DNA (double- and single-stranded), were all negative. C3: 0.60 g/l, C4: 0.20 g/l, CH50: 80 u/ml, IgG: 11 g/l, IgA: 1.6 g/l, IgM: 1.5 g/l, IgD: 0.03 g/l, IgE: 300 u/l, i.e. all these values were normal.

Other laboratory results were within normal ranges. Histological examination of two different biopsies of involved skin showed in both some hyperkeratosis in epider-

mis. The dermis showed an increase of collagen and seemed sclerotic. A perivascular mononuclear cell infiltrate with lymphocytes was also observed. Direct immunofluorescence microscopy of biopsies showed in two species of involved skin a granular deposit in a linear fashion of IgG, IgM, IgA, C3 and fibrinogen at the dermal-epidermal junction. Uninvolved skin showed the same deposits of immunoglobulins at the junction area as did involved skin. These immunofluorescence findings were consistent with systemic lupus erythematosus but the patient's blood tests were not consistent with this disease.

DISCUSSION

This paper describes a young girl having clinical and histopathologic findings of morphea, where immunofluorescence microscopy findings (but not the serologic tests), showed systemic lupus erythematosus.

Winkelmann and associates (6) found by biopsy of involved scleroderma skin that IgM-band immunofluorescence was present in most patients with inflammatory scleroderma ("mixed connective tissue disease"). He also pointed out that patients with progressive systemic sclerosis and two patients with generalized morphea all showed negative immunofluorescence. Christianson et al. (2) reported 191 patients with either plaque type of morphea or linear scleroderma. None of these patients developed multisystem disease. However, Chorzelski & Jablonska (1) mention 3 cases of scleroderma with coexistence of lupus erythematosus - the discoid form in one and the systemic form in 2 patients. Dubois et al. (3) observed 3 patients with morphea who had positive LE cell preparations. All these 3 patients developed systemic lupus erythematosus several years later. Similarly, Tufanelli and co-workers (5) had a patient with linear scleroderma who developed systemic lupus erythematosus 12 years later. Mitchell et al. (4) described a child with circumscribed scleroderma with immunologic evidence of systemic lupus erythematosus. They stressed the importance of continued serologic investigations of patients with local scleroderma.

Possibly, the BCG vaccination may have been the trigger for the skin changes of this patient.

In summarizing, our patient with clinical morphea demonstrated immunological signs which can be interpreted as arousing a suspicion of systemic lupus erythematosus. We must therefore follow her carefully in the future to see if she develops symptoms of systemic disease. Similar cases were

mentioned in the literature but the nature of this combination (coexistence?) remains unknown.

REFERENCES

1. Chorzelski, T. & Jablonska, S.: Coexistence of lupus erythematosus and scleroderma in light of immunopathological investigation. *Acta Dermatovener (Stockholm)* 50: 81-85, 1970.
2. Christianson, H. B., Dorsay, C. S., O'Leary, P. A. et al.: Localized scleroderma: A clinical study of 235 cases. *Arch Dermatol* 74: 629-639, 1956.
3. Dubois, E. L., Chandor, S., Friou, G. J. et al.: Progressive systemic sclerosis (PSS) and localized scleroderma (morphea) with positive LE cell test and unusual systemic manifestations compatible with SLE. *Medicine (Baltimore)* 50: 199-221, 1971.
4. Mitchell, A. J., Rusin, L. J. & Diaz, L. A.: Circumscribed scleroderma with immunologic evidence of systemic lupus erythematosus. *Arch Dermatol* 116: 69-73, 1980.
5. Tufanelli, D. L., Marmalzat, W. L. & Dorsay, C. S.: Linear scleroderma with hemiatrophy. Report of three cases with collagen vascular disease. *Dermatologica* 132: 51-58, 1966.
6. Winkelmann, R. K., Carapeto, F. J. & Jordon, R. E.: Direct immunofluorescence in the diagnosis of scleroderma syndromes. *Br J Dermatol* 96: 231-238, 1977.

Leukaemia Cutis Mimicking Primary Syphilis

D. B. Czarnecki, T. J. O'Brien,
H. Rotstein and J. Brennan

*Dermatology Unit, St. Vincent's Hospital,
Melbourne, Australia*

Received December 22, 1980

Abstract. A 22-year-old man with acute leukaemia developed an indurated penile ulcer and regional lymphadenopathy. A biopsy of the lesion revealed a leukaemic infiltrate. The lesion showed a response to radiotherapy.

Key words: Acute leukaemia; Penile ulcer; Leukaemia cutis

In leukaemia, specific cutaneous deposits are uncommon on the genitalia (2). We have treated a patient with acute leukaemia who had a specific deposit which clinically resembled a syphilitic chancre. We wish to report this rare manifestation of leukaemia cutis.

CASE REPORTS

A 19-year-old male was diagnosed as having acute, undifferentiated leukaemia in 1975. Remission was achieved with cytotoxic therapy but he suffered several relapses over the succeeding years, each relapse being successfully



Fig. 1. The ulcerated lesion on the penis.