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Carteaud). The association between this disease and *Pityrosporum orbiculare* is discussed.

Key words: Confluent and reticulate papillomatosis; Tinea versicolor; *Pityrosporum orbiculare*

Confluent and reticulate papillomatosis (CRP) consists of greyish-brown pigmented papules which coalesce to reticulate and confluent patches. The disease was first described by Gougerot & Carteaud in 1927 (2), and only about 50 cases have been reported in the literature. It usually starts shortly after puberty primarily in females and is most often localized to the intermammary and interscapular regions.

The lipophilic yeast *Pityrosporum orbiculare*, the cause of tinea versicolor (1), has earlier been associated with CRP (4, 6). It is still not clear what the role of *P. orbiculare* is in CRP, whether it is the etiological agent, or if CRP represents an abnormal host reaction to *P. orbiculare* (4, 6). In tinea versicolor one sees both the yeast and the mycelial forms of *P. orbiculare*, but in CRP only the yeast form has been reported. The lesions of both tinea versicolor and CRP show a bright yellow fluorescence in Wood's light. Histological examination of CRP shows papillomatosis and hyperkeratosis, while in some areas there may be acanthosis and in others an atrophy of the malpighian layer.

CASE REPORT

A 16-year-old girl was admitted to the department because of brownish lesions on her cheeks of 4 months' duration

One Case of Confluent and Reticulate Papillomatosis (Gougerot-Carteaud)

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Abstract. A 16-year-old girl with dark-brown coalescing papules symmetrically localized to the cheeks, is reported. The diagnosis may be consistent with the criteria for confluent and reticulate papillomatosis (Gougerot-

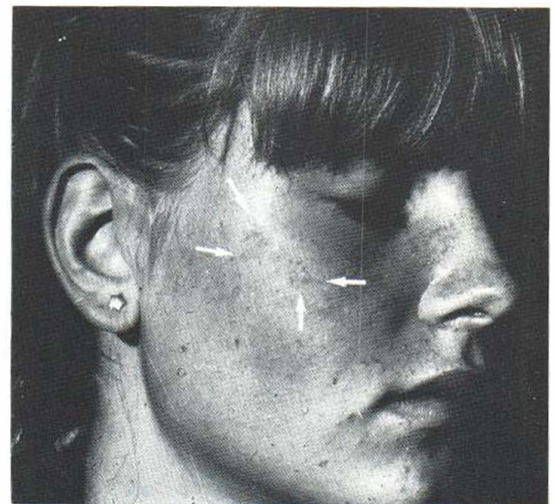


Fig. 1. Hyperpigmented confluent papules on the cheek.



Fig. 2. Slight atrophy of the malpighian layer and a slight perivascular infiltrate of lymphocytes and granulocytes. H-E. $\times 103$.



Fig. 3. *Pityrosporum orbiculare* yeast cells localized in the stratum corneum. PAS. $\times 330$.

(Fig. 1). The lesions consisted of dark-brown papules coalescing to form a plaque of approximately 3×5 cm on both cheeks. The lesions showed a bright yellow fluorescence in Wood's light and microscopy (Scotch tape stained with methylene blue) showed numerous clusters of *P. orbiculare*, but only in the yeast form.

Skin scrapings for culture were taken with a curette on a peptone-glucose-yeast extract medium containing glycerol monostearate (2.5 g/l) and Tween (2 ml/l), overlaid with olive oil. Culture showed abundant growth of *P. orbiculare*. Histology showed atrophy of the malpighian layer and a non-specific perivascular infiltrate of lymphocytes and granulocytes in the dermis (Fig. 2). Periodic acid-Schiff stain (PAS) showed some *P. orbiculare* yeasts in the stratum corneum (Fig. 3).

The patient was treated with miconazole cream 2% and the lesions disappeared after 2 weeks, as judged clinically, in Wood's light, and microscopically. They reoccurred however on the right cheek after further 4 weeks, but disappeared again after the same treatment. After 4 weeks they reoccurred, now on the left cheek, but again they disappeared after treatment with miconazole cream.

DISCUSSION

The aetiology of CRP is still unknown. The disease is most often seen in females shortly after puberty and an endocrine disturbance has been suggested, but most of the patients have been in good health. Roberts and Lachapelle associated *P. orbiculare* with CRP (4), but the role of *P. orbiculare* in CRP is still unknown. That the presence of *P. orbiculare* is significant in CRP is suggested by the beneficial effect of antifungal agents both in this and in other reports (4, 6). CRP is usually localized to seborrheic areas on the trunk and more seldom to the face, arms or legs. In this case lesions were only seen on the cheeks and the histological picture did not show hyperkeratosis or papillomatosis. The clinical picture in connection with fluorescence in Wood's light and the presence of *P. orbiculare* microscopically confirmed the diagnosis of CRP. The lesions reoccurred after a short period but each time they disappeared after antifungal treatment.

P. orbiculare links CRP to tinea versicolor. Even the distribution primarily to seborrheic areas, the pigmentary disturbances, and the clearance of lesions with antifungal agents show similarities. In tinea versicolor the conversion of *P. orbiculare* from the yeast form to the mycelial form is responsible for the disease (3, 5). In CRP this conversion is not seen and an abnormal host response to the fungus rather than a strictly infectious reaction may better explain the role of *P. orbiculare* in this disease.

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Eosinophilic Fasciitis (Shulman Syndrome) in a 13-year-old Girl

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Abstract. Symptoms compatible with the diagnosis of eosinophilic fasciitis (morphea-like changes of the skin, restricted joint movement, eosinophilia, elevated immunoglobulin levels in serum) in a 13-year-old girl and the response to systemic corticosteroid treatment are reported. The literature is reviewed.

Key words: Eosinophilic fasciitis; Shulman syndrome; Localized scleroderma; Eosinophilia

In 1974 Shulman described in two male patients what he thought to be a new syndrome, characterized by localized cutaneous morphea-like changes (typically of the extremities, with varying degrees of mobility restriction of the joints), severe inflammation of the deep fasciae, eosinophilia, and selective elevation of IgG levels (12).

Up till now 35 cases of this "eosinophilic fasciitis" (EF) have been reported, almost exclusively in the US (Table I), but to our knowledge none have been described in Scandinavia. In spite of the rather alarming symptoms, early systemic treatment with corticosteroids seems effective. For this reason we