

Examination of biopsy specimens from the cheek and scrotum revealed non-caseating epithelioid tubercles surrounded by a sparse lymphocytic infiltrate. The cheek specimen contained granulomas only in the upper dermis, while granulomas with surrounding fibrosis extended into the reticular dermis in the scrotal specimen. There was no evidence of lymphedema in the scrotal specimen. Staining for acid-fast bacilli and PAS staining for fungi were negative. No foreign bodies were detected by polarizing light.

Therapy was initiated with topical fluocinonide 0.05% cream applied three times daily, oral prednisone at 60 mg/day, and a scrotal sling. Unfortunately, the patient did not return to the clinic for his scheduled follow-up appointment. When the patient reappeared 2 months later, his scrotum was markedly more edematous than on his initial examination, and his facial lesions were unchanged. The patient's non-compliance with therapy contributed to the additional scarring of the scrotum, which was evident on his follow-up physical examination. Oral prednisone at 60 mg/day was restarted, with a plan to re-evaluate the patient in 2 weeks. We considered further treatment with higher doses of prednisone, methotrexate, antimalarial agents, minocycline, or other immunosuppressants, but the patient was subsequently lost to follow-up.

DISCUSSION

Although the exact etiology of sarcoidosis remains unknown, data suggest that it arises in genetically predisposed individuals who have been exposed to a variety of environmental antigens. For example, *Mycobacterium tuberculosis* and atypical mycobacterium species have been isolated from skin and blood samples of patients with sarcoidosis, leading to the hypothesis that the disease might be an extreme form of tuberculosis (1). Human herpesvirus 8 (HHV-8) DNA has also been

detected in tissue samples from the lungs, lymph nodes, oral mucosa, and skin of patients with sarcoidosis, suggesting another possible infectious factor (2). Other researchers did not find serologic evidence of HHV-8 in patients with sarcoidosis (3). Proof of an infectious cause remains a subject of active investigation (4).

Although previous case reports describe sarcoidosis presenting as testicular or epididymal masses without cutaneous lesions (5–8), we believe that this case represents the first case report of cutaneous scrotal and penile lesions as one of the presenting signs of systemic sarcoidosis. Sarcoidosis originating as a scrotal mass limited to the tunics has been reported (5). In this case, a 5-year-old boy presented with fever and an intrascrotal mass extending through all the tunics, but with no skin lesions and no testicular involvement. Our case demonstrates that gross enlargement of the scrotum and penis resembling anasarca can result from the infiltration of sarcoidal granulomas in the skin without any sarcoidal lymph node involvement.

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Erythema Multiforme-like Molluscum Dermatitis

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Sir,
Classical molluscum contagiosum (MC) has the clinical appearance of a smooth-surfaced and pearly papule with central umbilication. In at least 10% of cases, particularly in atopic subjects, a patchy eczema, often very irritative, develops around one or more of the lesions a month or more after the onset of MC (1). Sporadic cases of this

molluscum dermatitis with atypical presentation have been reported (2, 3). Here, we describe a case of MC presenting as severe, erythema multiforme-like, targetoid eczema in a patient with atopic dermatitis.

CASE REPORT

A 7-year-old boy presented with pruritic targetoid eczema on the lower extremities (Fig. 1). Scattered

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umbilicated papules, typical of MC, which were also present, developed one month prior to this targetoid eczema. In the center of the targetoid lesions, small necrotic or crusted papules were observed. The patient also suffered from atopic dermatitis with concurrent, mild, flexural eczema.

The umbilicated papules were confirmed by microscopic examination as MC and the targetoid eczema showed dense perivascular inflammatory cell infiltrations consisting mainly of lymphocytes and eosinophils. Small foci of epidermal keratinocytes contained basophilic molluscum bodies with mild hyperplasia and spongiosis. Molluscum bodies were also observed in the epithelium of a vellus hair follicle surrounded by lymphocytes.

The targetoid eczema was resolved by curettage of the MC and the topical application of hydrocortisone.

DISCUSSION

M. contagiosum may have atypical clinical presentations in healthy subjects, as well as in immunosuppressive conditions and atopic patients. MC may cause perilesional eczematous reactions, especially in atopic patients (1). Molluscum dermatitis usually develops in the form of erythematous patches (1) and rarely as erythema annulare centrifugum (2) or as ecthyma-like lesions (3) around the molluscum papules. In contrast to molluscum dermatitis, which develops immediately around the MC papules, a so called id reaction has been reported in a few cases, in which eczematoid lesions occurred separately from the viral papules. Moreover, clinically these lesions simulated erythema multiforme, erythema nodosum, erythema annulare centrifugum, lichen scrofulosorum, dyshidrotic eczema, seborrheic dermatitis, lichenoid and sarcoid-like lesions (4).

In our patient, an unusual erythema multiforme-like targetoid eczema was observed around each papule of *m. contagiosum*. This was not a true erythema multiforme lesion or id reaction, but a localized eczematous reaction from MC. Perilesional targetoid eczema, clinically simulating erythema multiforme, could have been a severe form of eczematous reaction or molluscum dermatitis. However, it is not likely that the erythema multiforme-like targetoid eczema was a clinical mani-



Fig. 1. Targetoid eczema around molluscum papules on the lower extremities.

festation of follicular MC, which has been reported to show deeply situated waxy papules (5). In our patient, the atopic eczema was clinically of a mild degree, of which the parents were unaware, although the MC had developed into an atypical erythema multiforme-like eczema. This observation suggests that molluscum dermatitis or eczematous reaction could occur regardless of the clinical severity of atopic dermatitis.

Erythema multiforme-like eczema could be a rare form of molluscum dermatitis that occurs around the molluscum papules; moreover, patients with atopic dermatitis might be more predisposed to this eczematous reaction.

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