

## Cutaneous Lesions of Multicentric Reticulohistiocytosis Developing in Herpes Zoster Lesions

Sir,

Multicentric reticulohistiocytosis (MCRH) is a rare systemic disorder of unknown cause involving skin, mucosae, subcutaneous tissue, synovia, joints and, at times, periosteum, which results in destructive arthritis (1). About 30% of MCRH patients have an underlying malignancy of gastric, ovarian, breast or uterine origin or lymphomas (2).

A 43-year-old man, a known follow-up patient of MCRH (3) had asymptomatic, erythematous, papular and nodular lesions on the skin involving the trunk, both upper and lower extremities, ears and nape of the neck. He had symmetrical polyarthritis that began in the neck and shoulder joints. Over the next few days it had spread to involve the other joints, including the small joints of the hands and feet. Other systems were not involved.

The patient had been treated with oral methotrexate, 15 mg weekly for 6 months, and intravenous cyclophosphamide, 750 mg monthly for 1 year, with some relief, although he continued to develop new lesions. He was then started on intravenous dexamethasone 100 mg on 3 consecutive days every month. There was a significant improvement in his skin and joint lesions after 4 months of therapy. He continued this treatment to a total of 20 cycles, with about 80–90% improvement, following which he stopped the treatment of his own accord. The lesions reappeared 3 months after termination of therapy. There were numerous shiny, erythematous, scattered nodules on the abdomen, the front of both thighs, the right hand, surrounding the proximal nail fold of both the thumbs, the right index and 2 middle fingers of the left hand, both ears and the nape of the neck.

The patient had developed herpes zoster along the left lumbar region (L<sub>4</sub>). Fifteen days after the lesions healed, similar asymptomatic, shiny, erythematous papules developed at the site of healed lesions of herpes zoster (Fig. 1). Routine investigations, such as haemogram, liver and renal function tests, blood sugar, serum electrolytes, stool examination, urinalysis and chest X-ray, were normal. X-ray of both hands showed multiple lytic lesions involving distal and proximal interphalangeal joints, carpals and metacarpal heads and bases. There were endocortical erosions of the radial and ulnar articular surfaces. X-ray of the shoulder joints showed erosion around the humeral head. Histopathology of the skin lesion showed large number of multinucleated histiocytes



Fig. 1. Papular lesions of multicentric reticulohistiocytosis in a dermatomal pattern on herpes zoster scars.

along with fibroblasts, confirming the clinical diagnosis of MCRH.

Cutaneous MCRH appearing on herpes zoster lesions in a dermatomal pattern has not been described previously, but has been reported in patients with lymphomas (4).

### REFERENCES

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