genital and perineal areas (9). In addition, purely penile pyoderma gangrenosum has been described (10, 12–14).

SGP is usually seen in adults, with a predilection for the trunk (3,15). To the best of our knowledge, this patient is the first reported case of SGP located on the scrotum. Behçet's syndrome and fixed drug eruption must be considered in the differential diagnosis. However, there was no history of the use of any drug in our patient. In addition, the major criteria of Behçet's disease were absent and the pathergy test was negative.

Oral prednisone with 40 to 120 mg/day has been recommended for treatment of PG except SGP variant (3, 16). SGP has an indolent course, with less toxic treatment modalities (1, 3, 4, 15). Local corticosteroid, oral tetracycline, minocycline and sulpha drugs have been used successfully for SGP (3, 15).

Oral tetracycline 2 g/day and clobetasol-17-propionate cream gave no beneficial effect in this case. Systemic corticosteroid therapy is not generally recommended for the treatment of SGP but prednisolone 20 mg/day provided rapid healing with an acceptable cosmetic scar in 3 weeks.

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Successful Treatment of Ulcerated Necrobiosis Lipoidica with Mycophenolate Mofetil

Sir,

Necrobiosis lipoidica is a granulomatous inflammatory disease of the skin usually associated with diabetes mellitus. About a third of patients suffering from necrobiosis lipoidica show painful ulcerations of the involved skin which are usually resistant to therapy. We describe here a case of necrobiosis lipoidica where the ulcerations healed after treatment with mycophenolate mofetil (MMF).

CASE REPORT

A non-diabetic 61-year-old women with a 30-year history of necrobiosis lipoidica presented with ulcerations of both lower legs that had existed for 18 months. Sharp-bordered, yellow–brown to red painful plaques were observed with ulcerations, atrophia and sclerosis of the centre and elevation of the margin.

A biopsy specimen of the lesional skin confirmed the diagnosis and showed collagen degeneration with a concomitant palisading granulomatous infiltration (composed of giant cells, epitheloid cells and histiocytes) in the lower dermis. This granulomatous infiltration was surrounded by a distinct, perivascular inflammatory cell infiltrate featuring plasma cells. We also observed leukocytoclastic vasculitis with obliterated vessels and septal panniculitis.

The ulcerated lesions had failed to respond to a number of previous long-term treatment regimens with topical (under occlusion) and oral (60–80 mg per day) corticosteroids, pentoxifylline, dapsone and topical antiseptic substances combined with prolonged compression. The patient also received heparin. Nevertheless, the ulcerations persisted continuously for >18 months and hardly any improvement was noticed (Fig. 1A).

As plasma cells were the most numerous cells in the lesional skin and may therefore play a crucial role in the pathogenesis of necrobiosis lipoidica, we decided to start treatment with lymphocyte-inhibiting MMF (1) at 1 g per day orally divided into 2 doses of 0.5 g. The extensive ulcerations of both lower legs completely regressed within 4 weeks after this therapy was begun (Fig. 1B). The daily dose was subsequently reduced to 0.5 g. After 4 months of treatment the patient was still free of ulcerations. Complete elimination of MMF by the patient resulted in the recurrence of ulcerations within 14 days. The patient refused further therapy with this drug, because she feared the side effects of MMF, although she did not complain of any side effects and we could not observe any during the entire duration of therapy.

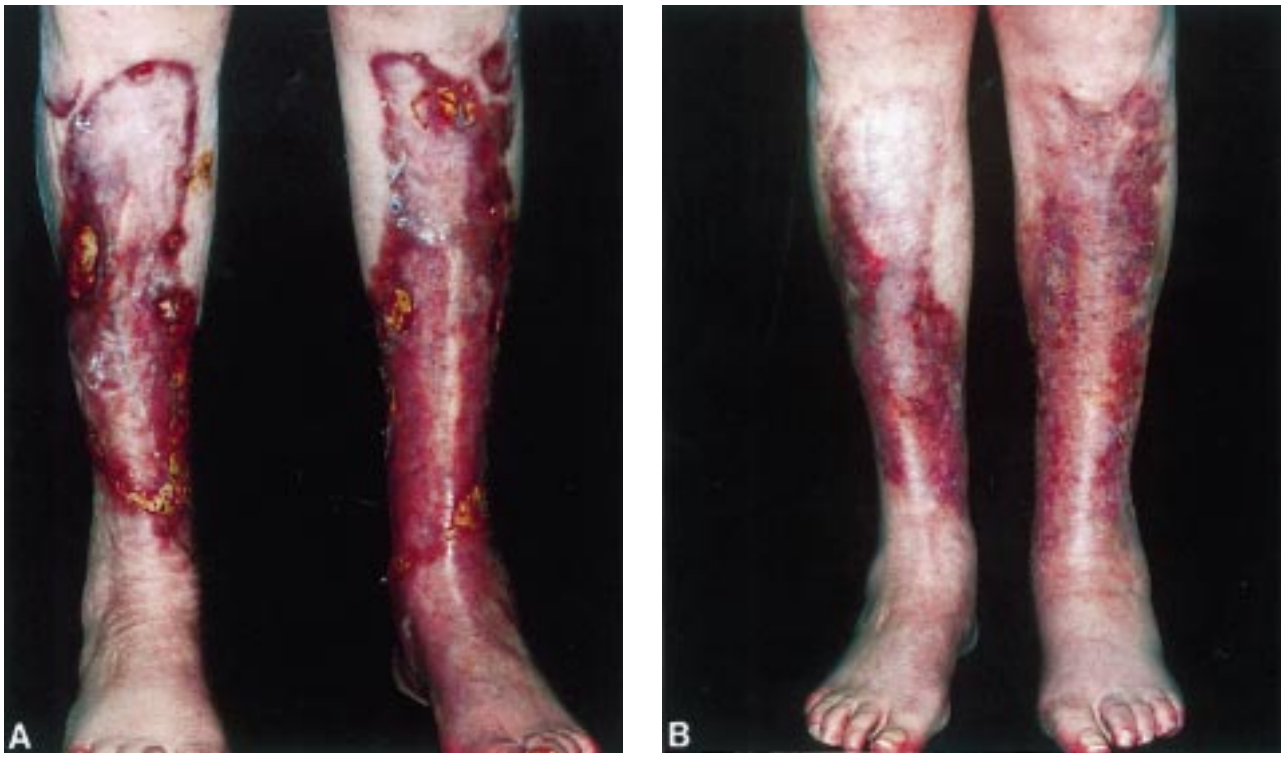


Fig. 1. Lower legs of the patient before (A) and 4 weeks after (B) the beginning of therapy.

DISCUSSION

MMF is used as a potent immunosuppressant for prevention and treatment of renal-transplant rejections (2). However, treatment of bullous pemphigoid (3), psoriasis vulgaris (4) and other diseases with MMF is promising. Here, we provide evidence that MMF may be useful in the management of otherwise therapeutically resistant ulcerated necrobiosis lipoidica.

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A Suppurating Fistula from a Cement Foreign Body Presenting as a Tumour of the Nail

Sir,
Nail malignant tumours are not very common and, when diagnosed, tend to cause great alarm amongst patients as well as physicians. The condition is often initially misdiagnosed (1).

CASE REPORT

We report here on a 19-year-old male who complained of a lesion on his right toe. One and a half years earlier there had been some surgical intervention on a bone in that toe. The patient was informed that the surgeon had "cured a cyst" in his bone and put in an osseus graft. During the 3 months prior to his visit he had a recurrence of pain and swelling, with purulent discharge. A colleague described this as a hemorrhagic tumour close to the nail. In addition to a homolateral inguinal adenopathy, the clinical findings led to the differential diagnosis of a pyogenic granuloma or an ulcerated melanoma.

On clinical examination we discovered, adjacent to the proximal nail fold, an emerging round tumour with a clear peripheral and dark central area. There was some purulent and hemorrhagic exudate. This was firm and moderately painful on palpation and was responsible for a slight limp. The nail plate appeared dystrophic (Fig. 1). X-ray showed a homogeneous radiopaque body at the center of the distal