

Table I. Mean immunoglobulin levels ($\pm$ S.D.) in three groups of subjects with varying degrees of alopecia areata and a control group age- and sex-matched with the most severely affected group

Normal range in parentheses

Area of scalp involved	$< 1/3$	$1/3-2/3$	$> 2/3$	<i>p</i>	Controls
IgA g/l (0.9-4.5)	2.28 $\pm$ 1.18	1.76 $\pm$ 0.85	1.63 $\pm$ 0.86	n.s.	1.96 $\pm$ 0.71
IgM g/l (0.6-2.8)	1.51 $\pm$ 0.60	1.35 $\pm$ 0.40	1.11 $\pm$ 0.58	<i>p</i> <0.05	1.57 $\pm$ 0.67
IgG g/l (8.0-18.0)	11.29 $\pm$ 2.67	12.58 $\pm$ 2.04	11.43 $\pm$ 3.60	n.s.	11.46 $\pm$ 3.70
No. of subjects	19	16	20		20
Mean age in years	31	27	28		28
Subjects with atopic history	3	4	6		3

had alopecia totalis or universalis. There were no significant differences in the immunoglobulin levels of these subjects when compared with the rest of the group.

DISCUSSION

These results suggest that individuals with severe alopecia areata, alopecia totalis or alopecia universalis have lower levels of IgM and possibly IgA than unaffected or mildly affected subjects. It is not possible, however, to draw too many conclusions from this work in view of the small numbers of subjects in each group. Most of the immunoglobulin levels measured fell within the 'normal range' but the majority of values of subjects with over two-thirds of their scalp involved were at the lower end of this range.

Recently, a significant reduction in the number of circulating T cells in subjects with alopecia areata compared with age- and sex-matched controls has been described (1). B cells, however, appeared to be normal.

This work may further suggest that immunological factors are of importance in the pathogenesis of alopecia areata.

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Mycosis Fungoides with Verrucous Lesions

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Mycosis fungoides (M. F.) with papillomatous and verrucous lesions is a very rare disease. Very few



Fig. 1. Hyperkeratotic and verrucous plaques and tumours on the face.



Fig. 2. Hyperkeratotic and verrucous plaques and tumours on the leg.

cases appear to be mentioned in the literature (1, 2, 3, 4). We are able to present here another case, with verrucous lesions on the face and legs. The lesions were infiltrated plaques and tumours with a prominent verrucous appearance that gave a very peculiar clinical picture. In a wide clinicohistological study on M. F., the same authors (6) have proposed the term "verrucous plaques and tumours" for this specific type of lesion.

CASE REPORT

A 50-year-old male patient came to "Andreas Sygros" Hospital with a complaint of widespread skin lesions on the face, trunk and extremities. The patient stated that the exanthema had begun 3 years earlier and was characterized by the presence of well circumscribed erythematous and scaly plaques. On admission to hospital, the patient had a clinical picture consisting of a generalised scaly dermatitis of the trunk with scattered reddish-brown infiltrated plaques and tumours on the face, thighs and legs, which showed a characteristic papillomatous and

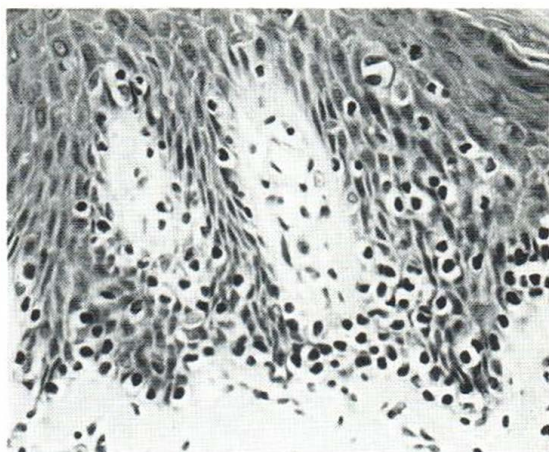


Fig. 3. "Bowenoid" type of Mycosis fungoides. (Haematoxylin-eosin, $\times 180$.)

hyperkeratotic surface (Figs. 1, 2). The patient complained of moderate itching. The inguinal lymph glands were moderately enlarged, mobile and indolorous. The spleen and liver were not palpable.

Blood examination revealed eosinophilia (10%), the ESR was moderately raised, 44/88, and the myelogram was normal. Overall X-ray examination did not reveal any pathological findings, but the clinical examination raised the possibility of mycosis fungoides and the diagnosis was confirmed histologically. The patient expired 2 years later and autopsy specimens revealed that the liver, spleen and lymph glands were involved.

HISTOLOGY

Biopsy material taken from the papillomatous and hyperkeratotic lesions gave the following histological



Fig. 4. Histological picture of Mycosis fungoides, showing two Pautrier microabscesses. (Haematoxylin-eosin, $\times 72$.)

picture: The epidermis showed hyperkeratosis, papillomatosis, acanthosis, elongation and branching of the rete ridges. The epidermis was diffusely infiltrated by cells which were characterized by a hyperchromatic, atypical nucleus. Some of the nuclei showed a crenellated periphery. The chorium was oedematous and the upper layers were moderately infiltrated by an admixture of cells consisting mainly of lymphocytes and histiocytes. The histological picture was consistent with the "Pagetoid" or "Bowenoid" type of Mycosis fungoides (5), (Fig. 3).

Biopsy material taken from non-verrucous lesions showed acanthosis, with elongation and branching of the rete ridges. The epidermis was infiltrated by "mycosis cells" which in some areas formed Pautrier microabscesses (Fig. 4). The upper layers of the chorium were densely infiltrated by an admixture of cells which consisted of lymphocytes, histiocytes and a considerable number of "mycosis cells".

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Disseminated Superficial "Actinic" Porokeratosis

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Abstract. An 81-year-old Finnish female had a 10-month history of a very pruritic eruption. In the clinical examina-

tion porokeratosis was suspected and histologically verified with the typical cornoid lamellae. The eruption involved also the unexposed areas of the skin. The patient had always avoided sunshine because it made her feel uncomfortable. The patient's sister, too, had a solitary lesion of porokeratosis. The pathomechanism of DSAP is discussed.

Key words: Porokeratosis; Cornoid lamella

Porokeratosis is a genodermatosis with autosomal dominant inheritance. The classic plaque type of the disease was first described by Majocchi in 1887 (6). In 1889 Mibelli termed the disease "porokeratosis", thinking that it would represent a disturbance in the keratinization of eccrine sweat ducts (5). Subsequently, different clinical types of porokeratosis have been described, all showing the typical histopathological finding, a parakeratotic cornoid lamella. Besides the classic localized porokeratosis of Mibelli, disseminated variants of the disease are also known (1, 10). In 1966 Chernosky reported on 12 patients with symmetrical lesions on the sun-exposed areas of the skin (2). This variant showed exacerbation following sun exposure. In 1967 Chernosky called this form disseminated superficial actinic porokeratosis (DSAP) (4). Unlike other types of porokeratosis DSAP usually begins after the third decade of life and the number of the lesions increases with age (3, 7).

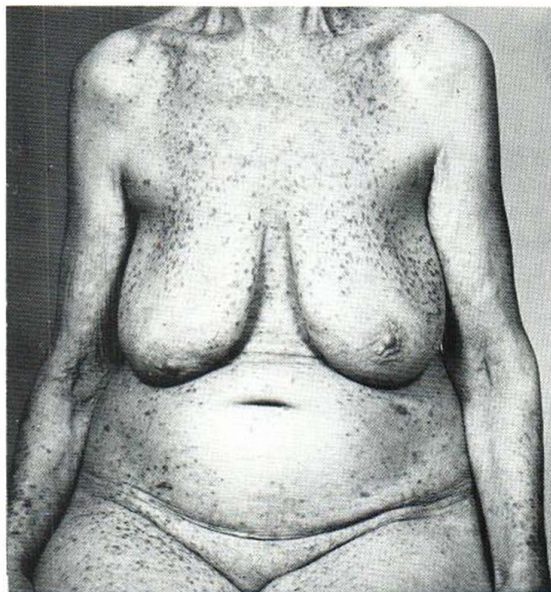


Fig. 1. The distribution of the lesions on the trunk.