

Waisman & Sutton (1966) and Goldman et al. (1974) have also described a similar group of patients, aged 4 to 17, with a recurrent pruritic papular dermatitis of the knees and elbows. Waisman & Sutton (1966) felt that friction (sand, wool rugs) was the cause, as these lesions occurred in the summer when short-sleeved shirts and pants are worn. Both authors noted recurrences in the summer but did not believe that atopy (asthma, hay fever or eczema) was related.

The group of patients reported here (Table 1) share the characteristics of Sutton's summer prurigo—youth, seasonal recurrences and pruritis. The number of patients indicates that the disorder is not uncommon and is perhaps even more common in areas with a longer spring season. It is not likely that Sutton's summer prurigo is a direct photo-allergic or photo-toxic reaction, since long-sleeved shirts are customary in Buffalo at the time the dermatitis appears. The unusual distribution also speaks against light as a significant agent.

Friction, as indicated by Waisman & Sutton (1966) is a nebulous factor common to all elbows. None of our patients gave a history indicating increased frictional trauma to the elbows and although we did not ask about the quality of our patients' rugs, none had exposure to sand.

Several of these patients are overt atopics and it is this author's speculation that the remainder are latent atopics. Why the elbows should represent such an unusual target site, however, is not known.

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## A Pustular Eruption of the Chin (a Variant of Pyoderma Faciale?)

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**Abstract.** Two cases are reported of patients who developed a dramatic pustulo-nodular rash on the chin. The onset was explosively sudden and cosmetically disabling. Ultimately, resolution occurred with minimal scarring.

In 1940 O'Leary & Kierland described an entity termed pyoderma faciale (2). This was characterised by a fulminating pustular eruption localised to the face. The rash was almost exclusively confined to young women. This problem has recently been reviewed by Plewig & Kligman (3), and deserves to be more widely recognized. We report two cases of a striking variant of this disease.

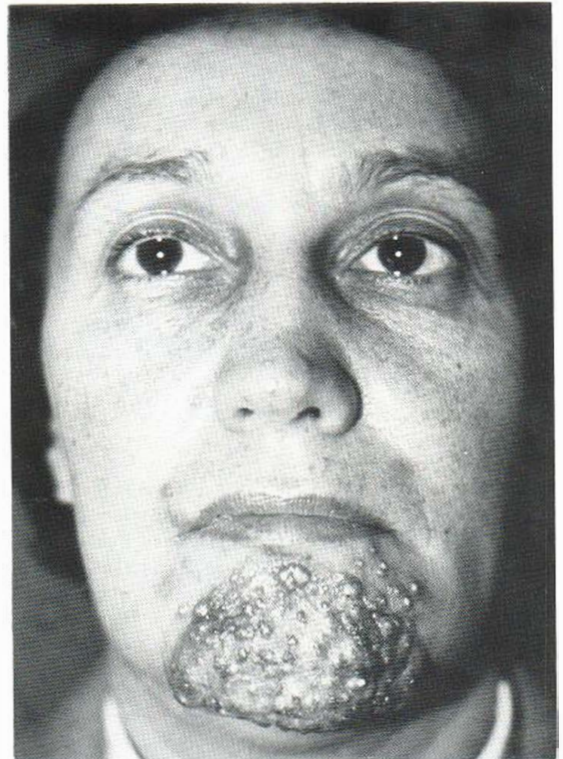


Fig. 1. Eruption on chin of Case 1.

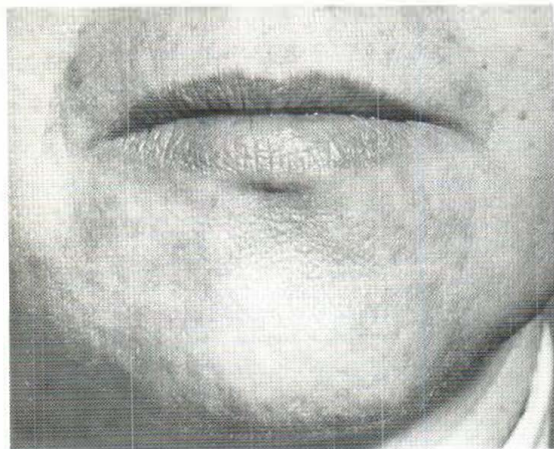


Fig. 2. Appearance of Case 1 after 2 months.

## CASE REPORTS

### Case 1

A 45-year-old woman presented with a 3-week history of massive pustules and nodules on her chin (Fig. 1). There was no previous history of skin disease, and her mild adolescent acne had not persisted into adult life. Shortly before presentation she had developed a dental abscess which required drainage and clindamycin therapy. She had not been treated with topical corticosteroids, nor halogen-containing preparations. On examination there was a marked, discharging furunculosis. There were no features of acne or rosacea on the unaffected areas of the face, back or chest. Swabs were taken for mycological and bacteriological examination. Both aerobic and anaerobic cultures were performed. The only organism isolated was a scanty growth of coagulase-negative staphylococci. An X-ray of the jaw did not demonstrate the presence of a dental sinus.

The patient was treated with superficial X-ray (100 r on three occasions) and sodium fusidate 2% ointment (Fucidin, Leo). Oral co-trimoxazole (Septrin, Wellcome) was prescribed but discontinued due to the development of a drug rash. The facial eruption slowly improved and was virtually clear after 2 months (Fig. 2).

### Case 2

A 43-year-old woman presented with a 2-month history of a pustular rash on her chin (Fig. 3). She had a long history of obstructive airways disease and had been treated with multiple short courses of systemic antibiotics. Three months before presentation systemic corticosteroid therapy had been started (prednisolone 15 mg daily). There was no history of halogen ingestion, and there was no active acne present elsewhere. Here too, culture of the abundant purulent exudate resulted in the growth of *Staphylococcus epidermidis*. The patient was treated with an antiseptic preparation containing hexachlorophane. The eruption resolved after 3 months and there has been only minimal residual scarring.

## DISCUSSION

Our two patients have several features in common. Both were middle-aged females with no previous history of severe acne or rosacea. The pustular eruption developed suddenly and was confined to the chin. No pathogenic organisms could be isolated from the affected sites.

Our initial clinical impression was that these patients had a gram-negative folliculitis (1). Both had received recent antibiotic therapy. However, neither showed the typical crops of pustules "fanning out" from the nose; bacteriological studies ruled out this diagnosis. Although the condition resembled bromoderma there was no history of the ingestion of halogen-containing preparations.

We next considered that the reaction may have been caused by hypersensitivity to the commensal organisms growing on the affected areas of skin. To test this hypothesis, prick and intradermal tests were performed on our first patient. The following sterile products of *Propionibacterium acnes* (*P. acnes*) Type I and *Staph. epidermidis* (*S. epidermidis*) were employed: (a) whole organisms (b) pressed cells (c) culture supernatant. No immediate nor delayed hypersensitivity was expressed to these preparations.

Finally, we concluded that our cases represented an even more localised form of pyoderma faciale. The characteristic features of this condition are:

1. It occurs in post-adolescent women.
2. It has an abrupt onset, and remains confined to the face.

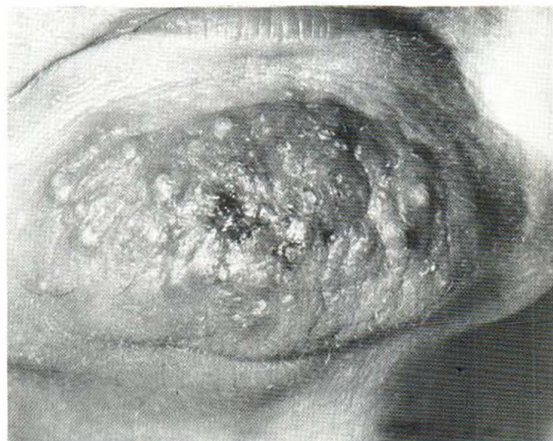


Fig. 3. Eruption on chin of Case 2.



3. Morphologically it resembles acne conglobata, consisting of pustules and aggregations of nodules.

4. Culture of the abundant purulent discharge does not result in the growth of organisms recognised as pathogenic.

The affected areas are sharply demarcated from adjacent normal skin. The patients have no constitutional symptoms. The disease attains its maximum extent within a few weeks or months and usually resolves within a year, with minimal residual scarring. Discussion with our colleagues indicates that this disorder may be more common than is usually appreciated. It should be recognised as distinct from acne vulgaris but its pathogenesis remains a mystery.

#### ACKNOWLEDGEMENTS

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### Malignant Angioendothelioma— Effect of Immunotherapy with *Corynebacterium Parvum*

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**Abstract.** An elderly patient with malignant angioendothelioma of the scalp is reported. Immunotherapy with killed *C. parvum* was used as an adjunct in treatment.

The majority of malignant vascular tumours are of subcutaneous or visceral origin and run a rapid

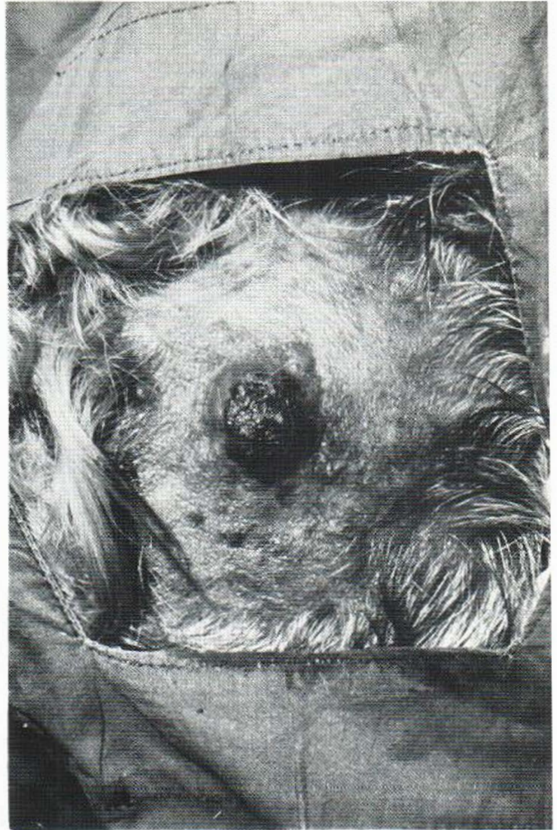


Fig. 1. Primary tumour.

course, with metastasis. Malignant angioendothelioma is a rare vascular tumour which Wilson Jones first delineated as a distinct clinical and histopathological entity (1). He reported nine elderly patients, seven of whom had rapidly progressive tumours of the face and scalp with metastases in unusual sites such as spleen, heart and intestines. Whilst radiotherapy may be palliative in most patients (2), wide excision with grafting appears to be the best form of treatment available at present.

This is a report of one patient with malignant angioendothelioma of the scalp who was treated initially by wide excision. Intratumour injection of killed *C. parvum* was then given in an attempt to control local recurrences.

#### PATIENT AND METHODS

A previously healthy man, aged 76 years, was seen in September 1974 with a three-month history of enlarging and bleeding nodules on the scalp. There had been no