DISCUSSION

In the two cases the clinical diagnosis of vasculitis was confirmed by microscopy. No signs of an actual or recent infection with B-haemolytic streptococci was established. In both patients staphylococcus aureus was isolated, which is an unusual cause of allergic vasculitis. In case 2 ampicillin treatment was started two days prior to the onset of vasculitis. The drug is not a likely cause, because after the treatment for scabies the vasculitis regressed in spite of a continuous supply of ampicillin.

In the two presented cases a prolonged scabies infestation is the most likely trigger of the reaction. Apart from allergic vasculitis on the lower legs, both patients had a clinically and histologically verified vasculitis surrounding the scabies burrows. We consider the vascular reaction related to the burrows as being comparable to a positive skin test. IgE antibodies to house-dust mites may be demonstrated in patients with scabies (1), but none of our patients had IgE antibodies or precipitating antibodies to house-dust mites.

Acute glomerulonephritis may follow a scabies epidemic (6) due to secondary infection with haemolytic streptococci. In the cases reported here, the scabies mite itself may be the primary cause of the glomerulonephritis, but a substantial proof for this explanation has not been established.

REFERENCES


Panniculitis in Pseudomonas aeruginosa septicemia

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A 71-year-old man developed multiple subcutaneous nodules during Pseudomonas aeruginosa septicemia. The acute and simultaneous flare of inflammatory nodules in a septic patient appears to be rather specific in Pseudomonas infections. Histological vascular lesions are prominent in the subcutaneous nodules. Key words: Panniculitis; Pseudomonas aeruginosa septicemia. (Received February 21, 1984.)

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The incidence of cutaneous manifestations in Pseudomonas aeruginosa septicemia ranges between 1.3\% (1) and 13\% (2). The classical skin lesion is ecthyma gangrenosum. Other cutaneous manifestations like hemorrhagic vesicles and bullae, gangrenous cellulitis, macular or maculopapular lesions resembling rose spots of typhoid fever, petechiae, ecchymoses and nodular cellulitis are less common (3). We report a case of Pseudomonas aeruginosa septicemia in which the only cutaneous manifestation was the presence of inflammatory subcutaneous nodules, which resolved with antibiotic therapy.

CASE REPORT
A 71-year-old male was admitted in our Hospital with a left apical lobe pneumonia. Forty-eight hours later, multiple subcutaneous nodules appeared. Clinical examination disclosed 25 to 30 inflammatory tender, nodular lesions distributed on the trunk, upper and lower extremities, all in the same stage of evolution, without ulceration of the overlying skin. Pseudomonas aeruginosa was isolated from blood, sputum and a cutaneous nodule. According to the antibiogram the patient was treated with azlocillin and gentamicin with progressive reduction of symptomatology, clearance of the chest X-ray film and resolution of cutaneous lesions in 25 days. Some of the cutaneous nodules became fluctuant, without ulceration.

A biopsy from a nodule of the leg showed liquefying panniculitis with extensive necrosis and dense neutrophilic infiltrate. Some small blood vessels, especially small venules, were found to show transmural basophilic necrosis of their walls, thrombosis, and sparse inflammatory infiltrate (Figs. 1, 2).

COMMENT
The presence of subcutaneous nodules in Pseudomonas aeruginosa septicemia has been stressed in occasional reports (4, 5) but always in association with other cutaneous manifestations. The case reported herein is exceptional because panniculitis was the only cutaneous manifestation.

Biopsy study of our case provided evidence of the pathogenesis of the lesion. The findings of vascular involvement, especially venules, with basophilic necrosis of the vessel wall and thrombosis without well-developed intramural inflammatory response are similar.
to those described in the more superficial lesions of ecthyma gangrenosum (6) and to those encountered in the lung in both experimental and clinical studies (7, 8, 9). A mechanism of invasion of the vessel wall from the periphery to the center has been postulated (7) although bacterial products may also play a role in the development of the lesion (7, 8).

Reed et al. (5) suggest that panniculitis might result from involvement of the deep venules while the more frequent cutaneous manifestations are due to superficial vascular lesions. According to the reported features P. aeruginosa septicemia can be included among the causes of acute panniculitis.

REFERENCES