The history as well as the clinical and histological findings in our patient were fully consistent with the diagnosis MR.

In clinically inconclusive cases, such as ours, histological examination may give the diagnosis as the histopathological findings are distinctive. Therefore histological examination of synovium after synovectomy should be carried out in patients with arthritis of unknown cause.

The differential diagnoses regarding the arthritis are sero-positive rheumatoid arthritis, sero-negative polyarthritis, paraneoplastic arthritis and crystal arthritis, which may all be accompanied by skin nodules, whereas the described skin lesions may resemble granuloma annulare, histiocytoma and sarcoidosis.

The prognosis is clearly influenced by a possible underlying malignancy. In our case, malignancy has so far been excluded.

As regards the skin lesions, about one-half will clear completely or improve after a few years; the other half will remain stationary or progress. The arthritis remains stationary in 50%; in the other half it progresses and may result in crippling arthritis of the hands.

There is no adequate treatment for the disease.

REFERENCES
DISCUSSION

The findings in our 5 patients were remarkably uniform. Only one had fever, loss of weight and nocturnal sweatings. Four of these patients were young adults in whom adenopathy developed in addition to their atopic dermatitis. The symptoms and dermatitis responded only to steroid therapy. Elevated sedimentation rates and eosinophilia were sporadic associated findings. All 5 patients had granulomatous Hodgkin’s disease, equivalent to nodular sclerosis and mixed cellularity in the current literature (2).

The concurrence of atopic dermatitis and Hodgkin’s disease is uncommon. In the series of Amlot & Green (1) of 15 patients with Hodgkin’s disease, 8 had atopy and only 2 of these had atopic dermatitis. However, their and our quoted cases raise the question whether chronic (atopic) dermatitis may evolve into lymphoproliferative disease. Degos (3) showed a relationship of dermatitis to mycosis fungoides and we have demonstrated a possible relationship between atopic dermatitis and Sézary’s syndrome (Rajka & Winkelmann, 5). Amlot & Green did not find any relationship between other forms of lymphoma and atopy, but they did not study curaneous lymphoma (1).

There is no direct evidence that atopic dermatitis either shields from or predisposes to tumour proliferation. A connecting such factor may be the reduced cell-mediated immunity (4) or presence of immunodeficiency in severe atopic dermatitis (6). It may be speculated that in non-atopic patients with Hodgkin’s disease, mycosis fungoides, or Sézary’s syndrome, the elevated IgE values may represent a direct stimulation of the IgE antibody system, a loss of T suppressor cell effect upon it, or a T helper cell effect. These mechanisms, especially the first two mentioned, might be operative also in our cases of atopic dermatitis with Hodgkin’s disease.

The practical consequence of our findings is that adenopathy in chronic atopic dermatitis should not be dismissed casually.

REFERENCES


Nevus Oligemicus with Sensory Changes

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Abstract. After a cold bath a 16-year-old man developed livid erythema with hot anesthesia on the trunk and arm, with unilateral topography. A similar case was previously reported, with lower frequency of lesions and absent sensory changes. The authors present another case with a similar topography but with persistent sensory changes in the lesions.

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