Arch Iranian Med 2008; 11 (5): 573 – 575

Photoclinic

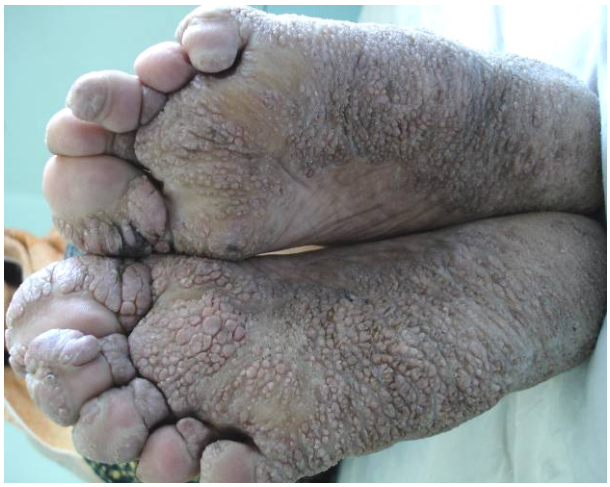

Figure 1. Confluent plantar vegetant and verrucous plaques.

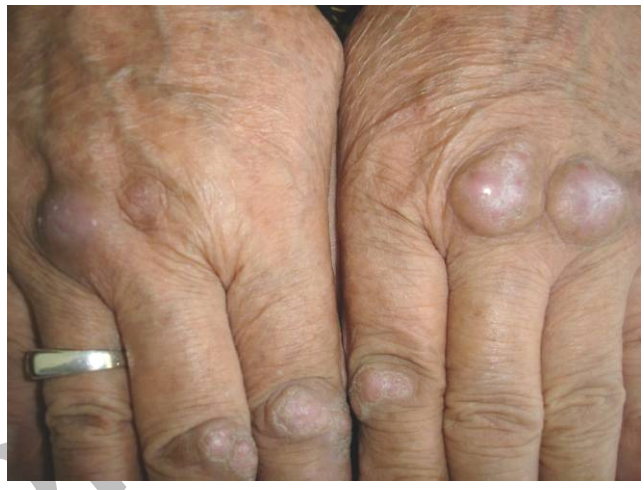

Figure 2. Violaceous nodules on the extensor surface of inter phalangeal joints.

A 57-year-old woman was referred to our center because of a two-year history of confluent plantar vegetative and verrucous plaques (Figure 1). These papules were firm and not compressible. She had edema in both legs. Later multiple violaceous nodules appeared on the extensor surface of interphalangeal joints (Figure 2). They were red-brown, indurated, with smooth regular borders and surfaces. She had considerable weight loss. She had no other relevant past medical history. IgA paraproteinemia have been identified through laboratory investigation, but there was no clinical or laboratory evidence for infectious diseases including HIV, autoimmunity, or hematological abnormalities. Skin biopsies were performed from hand nodules and plantar lesions.

Azita Nikoo MD*, Zahra S. Naraghi*
Author's affiliation: *Department of Dermatopathology, Razi Hospital, Tehran, Iran.
•**Corresponding author and reprints:** Azita Nikoo MD, Department of Dermatopathology, Vahdat Eslami Sq., Razi Hospital, Tehran, Iran.
Tel: +98-215-515-9988, Fax: +98-214-444-0471
E-mail: azinik@yahoo.com
Accepted for publication: 8 November 2007

What is Your Diagnosis?

See the next page for the diagnosis

Photoclinic Diagnosis: **Erythema *Elevatum Diutinum***

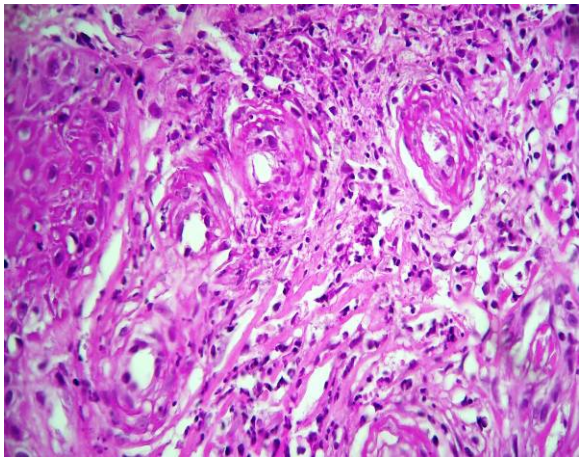

Figure 3. Leukocytoclastic vasculitis and fibrin deposition in the superficial dermis (early lesion).

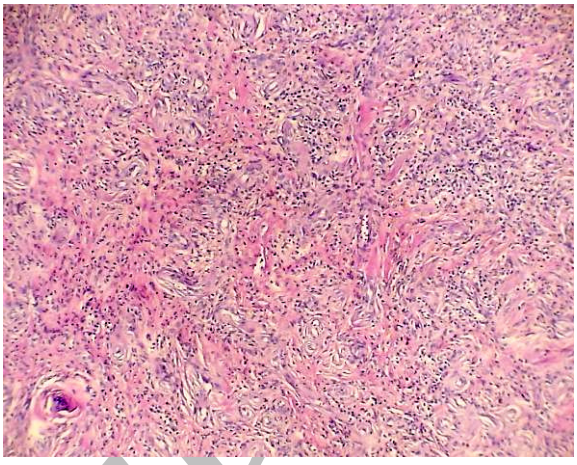

Figure 4. Perivascular concentric fibrosis (old lesion).

Discussion

Erythema elevatum diutinum (EED) is a chronic and rare dermatosis that is considered to be a variant of leukocytoclastic vasculitis. It is probably mediated by immune complexes. It is generally associated with autoimmune, neoplastic, and infectious processes.[1] Recently, it has been added to the group of specific dermatoses that are associated with HIV.[1,2] The typical clinical presentation was that of erythematous papules and plaques involving the extensor surfaces of the extremities,[3] and are usually located near joints such as the fingers, hands, elbows, ankles, and knees. Uncommonly, occurrences at atypical sites have been reported, including truncal, retroauricular,[4] palmar, and plantar lesions.[4,5] Recent reports of HIV-associated EED emphasize nodular lesions as well as palmar/plantar involvement. The histopathologic changes in early lesions begin with leukocytoclastic vasculitis (LCV) and polymorphonuclear cell infiltrate and fibrin deposition in the superficial and mid-dermis. Later lesions demonstrate a combination of granulation response or healing skin together with a proliferation of dermal spindle cells with or without multinucleate giant cells.[6] The deposition of circulating immune complexes in the dermal perivascular spaces induces an inflammatory cascade, which damages the vessels causing fibrosis.[7] At this stage, the histopathology may resemble sclerosing hemangioma, various types of fibrous histiocytoma or dermatofibrosarcoma protuberans.[6] A number of cases of EED occurring in patients with paraproteinemias, of which IgA is the most common isotype.[3]

Treatment of EED is difficult because this disorder runs a chronic and recurrent course. Treatment of the underlying cause or infection should result in improvement of EED. In most cases, dapsone or sulfonamides are considered the first-line treatment for EED.[6]

In the case reported here, plantar lesions was initially interpreted as a "paraneoplastic syndrome" such as acanthosis palmaris (triple palms) or acanthosis nigricans, wart and Kaposi sarcoma. EED was the first clinical suggestion for nodules of the hands. We found histological changes of EED in the biopsy specimen of plantar lesions and the lesions of the hands (Figures 3 and 4) Treatment with dapsone was effective for both types of lesions.

EED can be confused clinically with a number of skin conditions, and atypical clinical forms are usually diagnosed after histopathologic evaluations. We would like add plantar "vegetative and verrucous plaques" as one of the clinical presentations of EED, a feature that to our knowledge is reported in a few cases.

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Erratum

In the article entitled *The Establishment and the First Decades of the Activities of Pasteur Institute of Iran* was published in the Archives of Iranian Medicine, Vol.11, No.4, July 2008, P: 477 – 481, in the first paragraph of page 479, line 1 after the word arrived, the following part was omitted "…in Tehran on August 12, 1946 and after discussion with the Iranian officials, drew up the …"

We apologize to readers and authors for this error.