

with antibiotics were found to be inferior to antibiotic monotherapy.⁵ Despite treatment, 3–27% of patients with Lyme disease may experience antibiotic-refractory fatigue, dysaesthesia, myalgia or difficulty concentrating that can last months to years.^{3,5} Patients treated for Lyme disease do not develop an immunological response to protect against reinfection and there have been no documented cases of antibiotic resistance.^{1,5} Given the small set of documented cases in Australia, further research on tick-borne disease is required. Clinicians should be aware of the acute cutaneous presentation of an annular erythematous eruption in the returned traveller within the Australian setting.

Brent J Doolan¹  | Michael Christie² | Con Dolianitis¹
¹Department of Dermatology, and ²Department of Anatomical Pathology, The Royal Melbourne Hospital, Parkville, Victoria, Australia

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Supporting Information

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Table S1. Differential diagnosis for annular erythema.

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Case Letter

Dear Editor,

Contact dermatitis to Dermabond Advance®

Cyanoacrylate adhesives are recognized as a cause of post-operative allergic contact dermatitis as a result of increased use in the closure of surgical sites.

A 39-year-old woman underwent a laparoscopic cholecystectomy. One week after the surgery, she developed dermatitis at the port sites that had been closed with Dermabond Advanced (Ethicon, Inc., Somerville, NJ, USA). Four weeks after surgery she presented to the Dermatology Department with persistent dermatitis. She had no previous exposure to Dermabond, but had worn acrylic nails and used cyanoacrylate adhesives without evident contact dermatitis. Clobetasol propionate ointment was prescribed. During the following week, she developed a new plaque and satellite papules extending approximately 10 cm beyond the original areas of dermatitis (Fig. 1). The dermatitis resolved over the following 2 weeks with continued clobetasol propionate treatment. Subsequent epicutaneous patch testing was performed using Dermabond Advanced ('as is', unoccluded) and the T.R.U.E. Test (Smart Practice, Phoenix, AZ, USA). These materials were applied to the patient's back for 2 days and the results were observed 2, 3 and 7 days after application. The only reaction was to Dermabond Advanced: (++) according to the International Contact Dermatitis Research Group scoring system.

Dermabond is one of several skin adhesives containing octyl-2-cyanoacrylate. Several formulations have been marketed since 1999, including Dermabond Advanced. We identified 18 previous publications describing Dermabond allergic contact dermatitis, the first in 2008.¹ The diagnosis in most publications was confirmed by epicutaneous patch tests on normal skin with Dermabond 'as is'. However, in some patients, testing on abraded skin is necessary to elicit a positive reaction.² Although Dermabond and other cyanoacrylate adhesives contain trace amounts of formaldehyde, we did not find any published reports of allergic contact dermatitis from cyanoacrylate adhesives caused by formaldehyde. Consistent with this, our patient had a negative formaldehyde epicutaneous patch test. Allergic contact dermatitis is more likely caused by the cyanoacrylate.^{3,4}

In summary, it is important to be aware of the possibility of allergic contact dermatitis from surgical cyanoacrylate adhesives that may persist for many weeks and may result in autoeczematization.



Figure 1 Satellite papules and new plaque around the laparoscopic port sites 1 week after the initial visit.

Conflict of interest: none.

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Azusa Kanazawa¹ | Hirokazu Uno¹ | Tokio Nakada¹  | Daniel W Shaw² | Howard I Maibach⁵
¹Department of Dermatology, Showa University, Fujigaoka Hospital, Yokohama, Japan, ²Department of Dermatology, University of California, San Diego, and ³Department of Dermatology, University of California, San Francisco, California, USA

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Case Letter

Dear Editor,

Cervicofacial subcutaneous emphysema after facial cosmetic procedure in an 11-year-old girl

Cervicofacial subcutaneous emphysema resulting from maxillofacial surgery and dental procedures is well

described in the literature.¹ Other causes include facial and chest trauma, infections, iatrogenic causes such as endotracheal intubation, positive pressure ventilation and cryotherapy.^{1–4}

We report an 11-year-old girl who presented to the emergency department with swelling of her right cheek and neck. The swelling began soon after a cosmetic procedure for acne: mechanical cleaning of the skin pores followed by oxygen facial therapy. She also experienced a popping sensation, along with discomfort and swallowing difficulties. She had no significant medical history. There was no history of other traumatic events. She previously had the same cosmetic procedure four times without complications.

On examination she had right hemifacial and neck swelling with crepitus and mild pain on palpation. There were no systemic symptoms of infection or fever. There were no signs of dyspnoea or chest pain. A standard craniogram revealed s.c. air in the right cheek and neck consistent with the diagnosis of cervicofacial s.c. emphysema (Fig. 1a,b). There was no signs of pneumomediastinum on a chest radiogram. Ultrasonography confirmed an echogenic interface anterior to muscles, which obscured the view of the structures other than skin and fat tissue. Her blood test results were unremarkable. The patient was admitted for monitoring and managed conservatively with the antibiotic clindamycin as a prophylaxis for infection. The emphysema gradually resorbed within 2 weeks.

S.c. emphysema arises when air is forced beneath the tissues, leading to swelling, crepitus on palpation, and the potential of the air to spread along the fascial planes.¹ Usually cervicofacial s.c. emphysema is a benign and self-limiting condition, although it also may have life-threatening complications such as pneumothorax and pneumomediastinum, cardiac tamponade, air embolism, tracheal compression and mediastinitis.^{1,2}

A comprehensive search of medical literature in PubMed showed that s.c. emphysema from a facial injury is rare

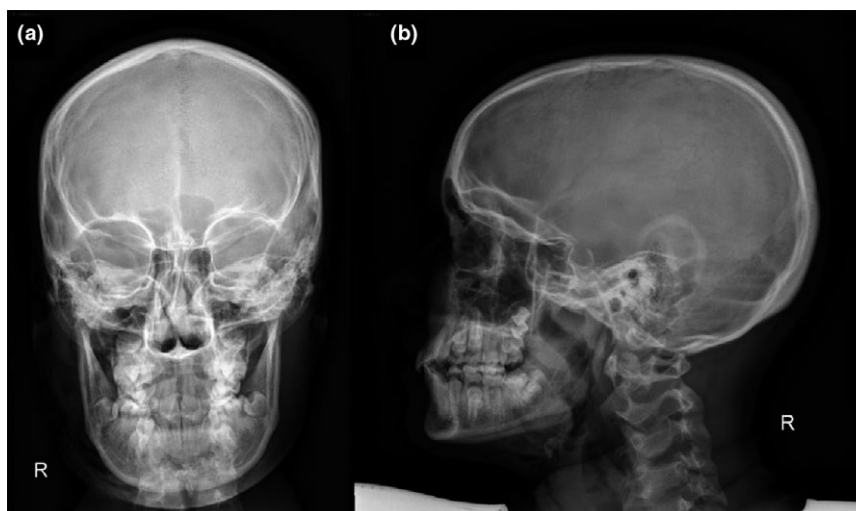


Figure 1 (a) A standard posteroanterior craniogram reveals s.c. emphysema in right cheek and right part of the neck. (b) A standard lateral craniogram confirms s.c. emphysema in the neck.