

Comment. The trumpet is a musical instrument made of brass, an alloy of varying combinations of copper and zinc.² Contact allergies to both of these metals is very rare,³ and most reported cases of trumpet cheilitis have been due to nickel contact allergy.^{4,5} Nickel and other metallic substances, although technically not part of the brass, are sometimes added to the alloy to achieve various effects.

Sound from a trumpet is produced by blowing air through tightly closed lips through the mouthpiece of the instrument. Because the mouthpiece was not well fitting in the present case, the patient was applying extra force to keep the instrument in close contact with his lips, and in the process he gradually injured his lips. In addition, he was playing the instrument for long hours every day without conditioning. These findings were clinically suggestive of mechanical trauma rather than allergic reaction. Moreover, the hand with which he was holding the trumpet showed no signs of the inflammation that should have been present had he been allergic to any component of the instrument material. Therefore, patch testing to confirm nickel or any other allergy was not performed, and the patient remained asymptomatic thereafter in spite of regularly playing the trumpet with the new, well-fitting mouthpiece.

It is very important to remind practicing clinicians as well as music trainers that proper conditioning and ergonomic modification of musical instruments are important to avoid mechanical injuries.

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Carcinoid Syndrome With Angioedema and Urticaria

The term *carcinoid syndrome* stands for a wide group of endocrine symptoms related to the presence of disseminated neuroendocrine cancer, such as diarrhea, flushes, and abdominal pain; infrequently wheezing and bronchial asthma; and rarely skin manifestations due to secretion of a variety of biogenic amines and peptides.¹ We report herein a rare case of carcinoid syndrome with angioedema and urticaria as the first symptoms of liver metastases of neuroendocrine cancer.

Report of a Case. A 52-year-old woman with diarrhea, abdominal pain, flushes, and dyspnea was admitted to the hospital in 2001. Well-differentiated neuroendo-

crine carcinoma of the cecum was diagnosed by laparoscopy, and she underwent chemotherapy based on doxorubicin hydrochloride and an ileocolostomy. All symptoms of carcinoid syndrome disappeared. In February 2002, angioedema of the upper lip and tongue with concomitant urticaria on the back and extremities appeared (**Figure 1**). There was no history of atopy or aspirin hypersensitivity. Results of typical diagnostic tests for urticaria (skin tests, fecal examination, a provocation aspirin test, test for complement components, thyrotropin evaluation, and testing for thyroid antibodies) proved negative. There was no response to antihistaminic drugs or glucocorticoids.

The patient's serum serotonin level was high at 1852 ng/mL (normal range, up to 450 ng/mL), and 5-hydroxyindoleacetic acid daily excretion was 33.5 mg/24 h (normal range, 2-8 mg/24 h) (to convert serotonin to micro-moles per liter, multiply by 0.000568; 5-hydroxyindoleacetic acid to $\mu\text{mol/d}$, multiply by 5.23). The catecholamine analogue metaiodobenzylguanidine (¹³¹I-MIBG) scintigraphy revealed pathologic focal uptake in the liver metastases (**Figure 2**). On the basis of the diagnostic scintigraphy, therapeutic ¹³¹I-MIBG was administered with palliative intent. Angioedema and urticaria were completely retreated with no additional pharmacotherapy. However, 11 months



Figure 1. Urticaria of the lower limb.

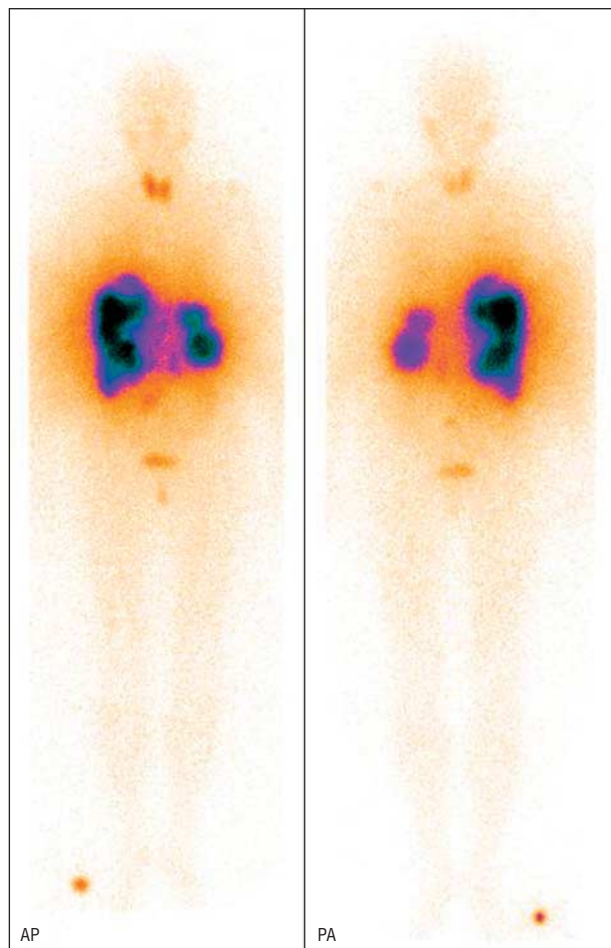


Figure 2. The catecholamine analogue metaiodobenzylguanidine scintigraphy revealed pathologic focal uptake in the liver metastases. AP indicates anterior view; PA, posterior view.

after the beginning of therapy, progression of the carcinoid syndrome symptoms was noticed, and urticaria symptoms (without angioedema) returned. The patient died in 2004 of progressive cancer.

Comment. Carcinoid syndrome with concomitant angioedema has been described in a few studies but never with urticaria.²⁻⁴ Carcinoid syndrome is caused by endocrine secretion of active peptides and amines that are synthesized and released by tumor cells. They appear in the circulation and cause symptoms only after development of liver metastases, which are drained by the hepatic vein. Active substances produced by the primary tumor located at the portal vein confluence are quickly metabolized by liver cells containing a large amount of monoamine oxidase and other enzymes. Thus, the active substances released by the tumor are inactivated until carcinoid syndrome spreads to the liver and releases them into the systemic circulation.³⁻⁵ Serotonin and, to a lesser extent, histamine are involved in the pathogenesis of angioedema and presumably also urticaria in carcinoid syndrome.

Feldman and Jones⁴ reported cases of carcinoid syndrome with angioedema without liver metastases. This is possible when the tumor discharges the biogenic products directly into the systemic circulation and circum-

vents hepatic metabolism. The history of neuroendocrine tumor in our patient was essential for prompt understanding of the causes of urticaria, which were confirmed by biochemical tests and ¹³¹I-MIBG scintigraphy.¹ Lack of effectiveness of typical pharmacotherapy with antihistaminic drugs or low doses of glucocorticoids could be attributed to the very high concentration of biogenic amines in the circulation. In this case, ¹³¹I-MIBG therapy caused temporary clinical improvement including alleviation of skin manifestations. To our knowledge, this is the first recorded observation of urticaria symptoms caused by a carcinoid tumor with improvement after ¹³¹I-MIBG treatment.

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Classic Mediterranean Kaposi's Sarcoma Regression With Sirolimus Treatment

Replacement of mycophenolate mofetil, cyclosporine, or tacrolimus by sirolimus results in regression of Kaposi's sarcoma (KS) in organ transplant recipients.¹⁻³ In these patients, clearance from KS might result either from reduced immunosuppression or from the direct antiangiogenic effects of sirolimus.

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Report of a Case. Herein we describe a 62-year-old man with disseminated Mediterranean KS that regressed almost completely during sirolimus therapy at a blood concentration of 6 ng/mL. The heterosexual, immunocompetent patient tested negative for both human immunodeficiency virus 1 and human immunodeficiency virus 2. However, he had 17 disseminated KS lesions that continuously erupted after excision of 2 single KS lesions that tested positive for human herpesvirus 8 and the D2-40 antibody (which is raised against M2A, an oncofetal antigen, and has been used as a marker for lymphatic endothelium). Owing to the large number of KS