

both in superficial and deep dermis, and a mild lymphocytic infiltrate. Laboratory tests showed lymphopenia, thrombopenia and slight elevation of liver enzymes. ACE concentration was normal. Chest X-ray and thoracic and abdominal scanning did not demonstrate systemic involvement of sarcoidosis. Mantoux, functional respiratory tests and EKG did not show any abnormalities. Lesions were treated with topical steroids with almost complete resolution in 5 months.

The combined therapy with PEG-IFN- α and ribavirin is known to activate T-helper lymphocytes promoting a Th1 profile immune response as a mechanism against viruses. This immune regulation also stimulates the development of cutaneous and autoimmune diseases.

Sarcoidosis has been extensively described in association with IFN- α treatment. Onset usually occurs between 3 and 4 months after starting IFN- α therapy for HCV chronic hepatitis. However, our patient had finished her treatment only 1 month previously. Similar cases with onset of systemic and/or cutaneous disease 1–6 months after treatment withdrawal are reported.¹ Cutaneous involvement in sarcoidosis related to IFN- α treatment is frequently described in the literature; among these cases, scar infiltration is estimated in approximately 17% of the patients.² Skin lesions usually have a good prognosis, even without stopping treatment. Thus, systemic steroids are recommended only for severe systemic sarcoidosis, because of the risk of reactivating the viral infection.

Until now, cases of cutaneous sarcoidosis in association with PEG-IFN- α plus ribavirin treatment for chronic hepatitis C have been described infrequently, probably due to the recent introduction of PEG-IFN- α . Hurst *et al.*³ offer a review of 13 cases of cutaneous sarcoidosis related to IFN- α treatment for HCV. Three cases with cutaneous sarcoidosis in the context of PEG-IFN- α plus ribavirin treatment are presented.^{3–5} Two patients had cutaneous and pulmonar lesions; one of them showed epithelioid granulomas affecting two tattoos and another patient (a 54-year-old woman) suffered reactivation of an old scar on the chin, as in our case. Nevertheless, our patient only presented cutaneous sarcoidosis and this was limited to old scars. Finally, the increasing number of patients suffering from chronic hepatitis C and the recent introduction of effective treatment with PEG-IFN- α plus ribavirin can be expected to result in further cases of sarcoidosis related to this therapy.

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Pellagra occurring in a patient with atopic dermatitis and food allergy

Editor

A 26-year-old gentleman with known atopic dermatitis (AD) presented with a rash on his upper chest and arms of 3 months' duration. He was adamant his rash was diet-related and insisted on allergy testing. AD was diagnosed. Tests showed an IgE > 5000 k μ /L (normal < 162) and positive specific IgE to a multitude of foods. The results were relayed to him 1 month later, and he was referred to a hospital dietician. A skin biopsy showed features of chronic dermatitis. Two months later he needed to be admitted. Further questioning revealed that he had always been very careful with his diet. As his eczema wasn't getting any better he had undergone 'allergy' testing at a health food store 2 months before coming to our department. There he was told that he was allergic to wheat, sugar and dairy products, which he subsequently avoided. Following the positive IgE results he restricted his diet even further, without formal dietary advice, to only baked beans and crisps.

Clinical examination revealed a symmetrical, hyperkeratotic confluent rash on the anterior torso, upper arms, and on the legs (fig. 1), suggesting pellagra. Blood tests showed a low vitamin B12 of 118 pg/mL (normal 145–900 pg/mL) and zinc level of 0.6 mg/L (normal 0.7–1.4 mg/L).

Oral nicotinamide and vitamin B were commenced. Within a week his rash had resolved (fig. 2). A hospital



fig. 1 The patient at the time of diagnosis.

dietician introduced a nutritionally balanced diet including many of the food products against which he had specific IgE. He tolerated them all very well. The gastroenterology team ruled out malabsorption. He remains disease free on a nutritionally balanced diet, except for mild eczema.

Pellagra can develop within 60 days of nutritional deficit and is often associated with concomitant deficiency in a second vitamin.¹ Any malnutritional state can provoke pellagra.² Various stages of dermatitis may be present on different body areas at the same time. Biochemical investigations to confirm the diagnosis are not considered reliable.^{1,3,4} Therapeutic response to niacin in a patient with the typical symptoms and signs of pellagra establishes the diagnosis. Treatment consists of a nutritionally balanced diet that is high in protein and adequate in calories, together with prolonged maintenance of nicotinamide and other vitamins, as the disease may still persist once the dermatitis has resolved.¹ This is a very rare presentation of pellagra in the context of AD.⁴ Our patient developed the photosensitive type of pellagra. The extent of his rash could be attributed to his underlying eczema.

In adult patients with AD, IgE-mediated food allergy plays only a very minor role in the disease process.⁵ Specific

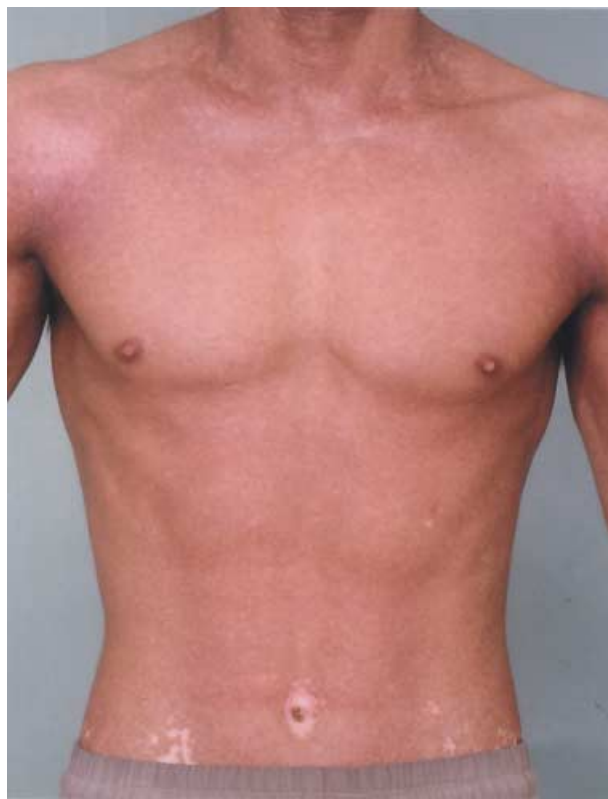


fig. 2 The same patient after 1 week's treatment with nicotinamide and vitamin B; the rash has completely resolved.

IgE tests to foods are not reliable in the diagnosis of food allergy.⁵⁻⁷ Negative specific IgE results are fairly reliable methods of excluding allergy. Positive results, however, only indicate the presence of IgE to an allergen or cross-reacting allergen and do not correlate with clinical reactions. Patients with AD can have very high levels of IgE (> 2000 Ku/mL) and care must be taken that the chosen laboratory methodology does not detect high levels of non-specific IgE that give rise to false positive results.^{2,7} Many adult AD patients follow elimination diets for long periods of time because of true or often suspected food allergies. A subgroup of AD patients has been identified as having dietary habits that result in significant nutritional deficiency, which impacts on homeostasis.⁸ Professional guidance for these patients, in order to eliminate only food that has been proven to elicit adverse reactions, is therefore imperative. Our patient's suspicion that his eczema was diet related, coupled with multiple positive 'allergy tests', was crucial in precipitating his pellagra. To our knowledge there are no studies that have looked at the impact of allergy testing on diet in patients with suspected food allergies.

We draw attention to the danger of 'allergy' testing in health food stores performed outside their medical context. Individuals are not made aware of the differences

between allergy, intolerances and hypersensitivities, and testing is not validated.⁹

This case illustrates the risks associated with avoidance diet without adequate supervision of a dietician and highlights the importance of establishing a proper dietary history in any patient with persistent skin rash and a history of so-called 'food allergy'.

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Immunocytoma: an unusual clinical feature

Editor

Cutaneous immunocytoma (lymphoplasmacytoid lymphoma) is a specific subtype of low-grade, malignant B-cell lymphomas, and is characterized by a proliferation of lymphoid lymphoplasmacytoid and/or plasma cells exhibiting monotypic intracytoplasmic immunoglobulin.¹



fig. 1 Red and violaceous infiltrated and ulcerative plaques over the cheeks.

Cutaneous immunocytoma may be primary or secondary.² Patients with cutaneous immunocytoma usually present with solitary or grouped nodules over the extremities.^{1–3} We report a case of secondary cutaneous immunocytoma with unusual clinical features.

A 74-year-old woman presented with a 3-month history of localized, red to violaceous infiltrated and ulcerative plaques over the cheeks, measuring 5 cm on the left cheek and 2 cm on the right cheek (fig. 1). Physical examination revealed several cervical lymph nodes, the largest measuring 3 cm, an enlarged spleen and a peripheral facial paralysis on the left side. Nasal endoscopy revealed a tumour of the right nary mucosa. Biopsy specimen of a skin lesion, a lymph node and nasal mucosa revealed a dense, diffuse infiltrate involving the papillary and reticular dermis. The infiltrate was composed of small lymphocytes, immunoblasts and plasmacytoid cells with intracytoplasmic PAS-positive inclusions (fig. 2). Immunohistochemical studies showed predominance of cell immunoreactivity for CD20 (B-cell marker). Blood sedimentation rate was normal. Complete blood cell count showed leucocytosis of $19\,000\text{ mm}^{-3}$. Serum protein and immunoelectrophoresis demonstrated high gammaglobulin at 84 g/L and a polyclonal band of Ig G. Flow cytometry performed on plasma cells showed that 58% of the cells were monoclonal B cells, which were negative for CD5 and positive for CD20, CD22 and CD79a. Bone-marrow biopsy specimen demonstrated lymphoid aggregates composed of small lymphocytes and plasmocytes, suggesting bone marrow involvement. Chest radiography showed an interstitial infiltrate.