

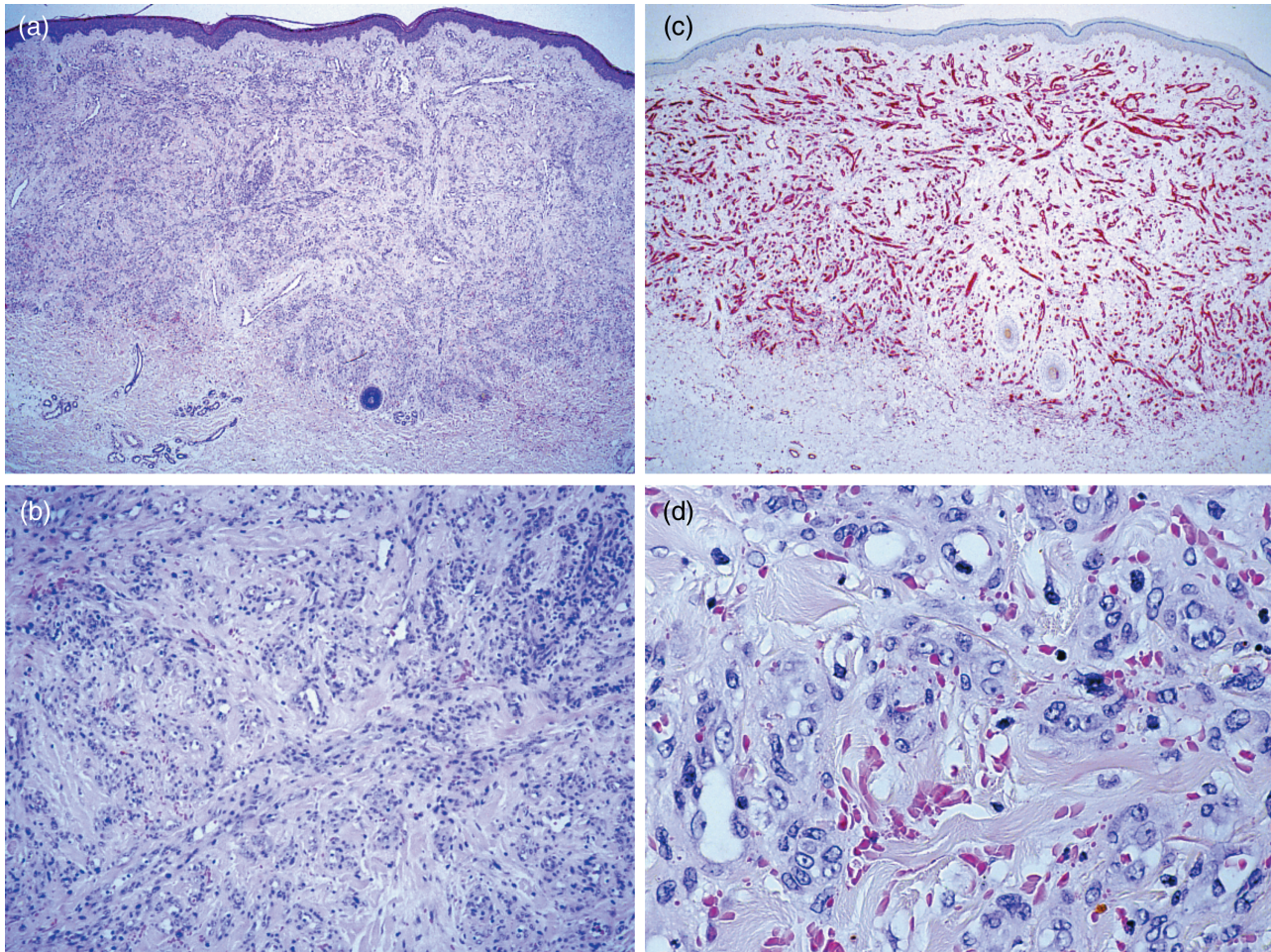


fig. 2 Histology of the knee lesion. (a) Relatively well-circumscribed, dermal nodule (b) composed of capillary forming endothelial cells embedded in a slightly fibrous stroma. (c) Slight epithelioid cell appearance. (d) CD31 immunoreactivity.

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DOI: 10.1111/j.1468-3083.2007.02288.x

Local and systemic allergic contact dermatitis due to dental alloys

Editor

Dental alloys are a well-known risk factor of local and systemic allergic contact dermatitis.^{1–4}

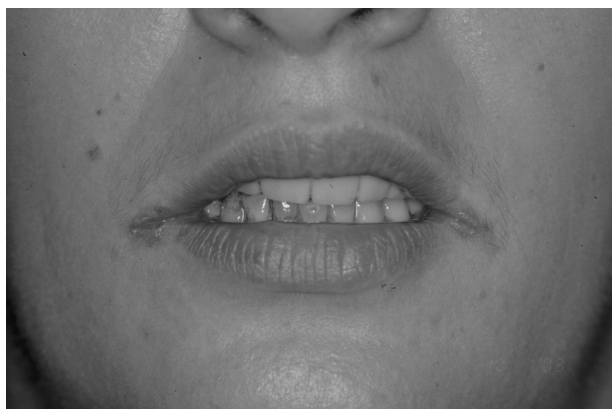


fig. 1 Commissural cheilitis and stomatitis at the presentation.

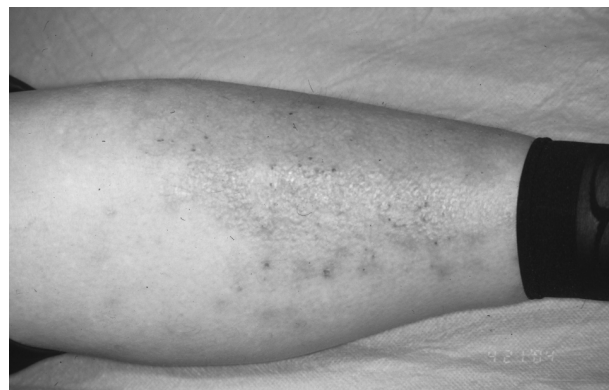


fig. 2 Acute eczematous contact dermatitis in the right leg associated with DVT.

We observed prospectively a case where severe allergic sensitization to dental alloys caused and sustained the patient's systemic contact dermatitis progression. A previously well 46-year-old atopic woman presented to our department in September 2003 because of a commissural cheilitis, stomatitis, and cutaneous dermatitis on her right forearm and forehead after an oral surgical intervention (fig. 1). Three weeks before admission, she received some titanium implants placed in one stage on the upper maxillary bone in vicinity to her teeth with dental amalgams. To rule out a potential allergy to dental materials, we did a patch test with a standard and dental series (Chemotechnique, Tygelsjö, Sweden).

She showed a strong allergy to dental amalgam (20%, ++) and extreme reaction to nickel sulphate (5%, +++) and palladium chloride (2%, +++). Skin prick tests were negative.

Meanwhile, a short course of topical corticosteroids was begun with partial beneficial effects. We suggested to her that she should remove the mercury fillings to minimize the electrocorrosion between amalgams and titanium fixtures, and other dental alloys, but she deferred the dental treatment. More importantly, we recommended her not to have further metallic-based dental restorations applied to avoid an increase of the electrogalvanic current, which would result in a sustained metals leakage.

After 6 months, the patient was readmitted to another department of the hospital due to proximal deep vein thrombosis (DVT) of the uninjured right leg. She had no history of DVT, nor did anyone in her family.

Notably, a bilateral dermatitis of her inferior legs preceded the thrombosis event (fig. 2). One month earlier, the patient had received an entire maxillary prosthesis based on chromium-cobalt alloy.

Basically, both cobalt and chromium are known to be as co-sensitivity with respect to nickel and palladium (rate of

cross-reactivity has been reported to be about 30% of the subjects).

The patient has been treated for 2 years with subcutaneous injections of heparin and topically applied steroids. At the time of the last visit, she was currently in clinical remission of both.

This report shows the particular clinical importance of patch testing for individuals at high risk for metal sensitization before dental approach.⁵⁻⁷

The present case convincingly highlights the particular clinical importance of patch testing for patients at high risk for metals sensitization before dental approach as well as its value for diagnosis of systemic contact allergy associated with dental alloys.

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DOI: 10.1111/j.1468-3083.2007.02289.x

Desmoplastic malignant melanoma evaluated with ¹⁸F-fluorodeoxyglucose positron emission tomography-computed tomography and sentinel lymph node biopsy

Editor

Desmoplastic malignant melanoma (DMM) is a rare fibrosing variant of malignant melanoma and is associated with a higher tendency for local recurrence, but metastases to regional lymph nodes are less common compared with conventional melanoma.¹ We report a rare case of primary desmoplastic melanoma evaluated with whole-body ¹⁸F-fluorodeoxyglucose positron emission tomography/computed tomography (¹⁸F-FDG PET-CT) and sentinel lymph node biopsy (SLNB). As far as we know, this is the first case of desmoplastic melanoma, which was evaluated by both ¹⁸F-FDG PET-CT and SLNB.

A 77-year-old Korean man visited our dermatologic clinic for evaluation of an enlarging nodule on the back. The mass had been present for 1 year and had undergone rapid growth with hardening and ulceration of the surface. On physical examination, the lesion showed a relatively well-demarcated 5 × 7 cm sized erythematous, telangiectatic and hard nodule with central ulceration on the right upper side of the back (fig. 1). There were no palpable lymph nodes in the both axillae or groins. Punch biopsy revealed extensive infiltration of atypical cells in the dermis with expansion to the subcutaneous fibrous septa, most likely poorly differentiated metastatic carcinoma. The diagnosis of carcinoma of uncertain origin was suggested, and ¹⁸F-FDG PET-CT was done in search of possible primary tumour. However, only the original tumour showed hot uptake (fig. 2), and no other lesion

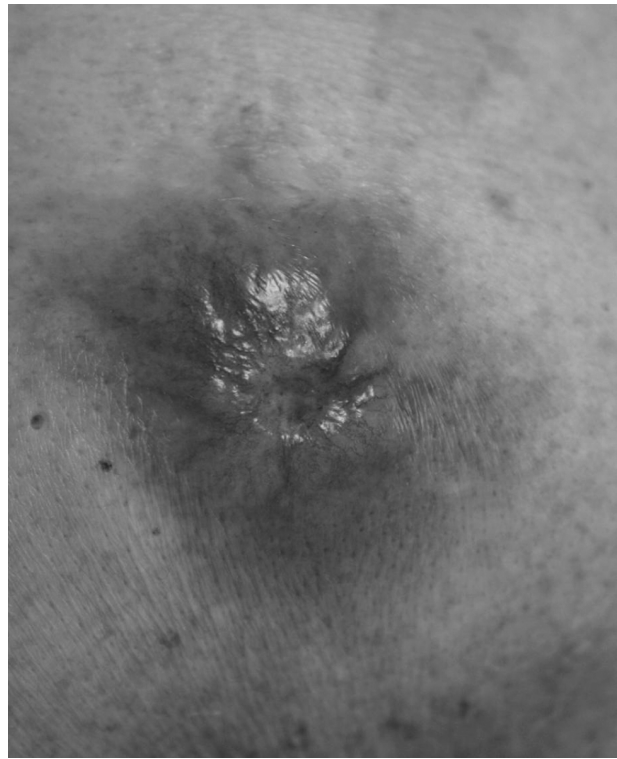


fig. 1 A relatively well-demarcated 5 × 7 cm sized erythematous, telangiectatic, hard nodule with central ulceration on the right upper side of the back.

was detected. Mohs micrographic surgery was done to completely remove the tumour, and the resected tumour showed several epithelioid tumour cell nests and fibroblast-like spindle cells in the dermis. In immunohistochemical staining, the cells stained positive for S-100 and desmin and negative for HMB-45. The diagnosis of DMM was made, and the depth was measured to be 10 mm. For staging purpose, SLNB was done after a lymphoscintigraphy with ^{99m}Tc-Technitium, and two of the three sentinel lymph nodes were positive. However, complete lymph node dissection of the axilla was negative, and the patient was referred to the oncology department.

PET-CT localises lesions with abnormal FDG uptake and has improved accuracy over PET alone. It takes advantage of the excellent anatomic resolution of CT and the biological characterisation provided by FDG PET, which together result in improvement in accuracy of detecting the extent of disease, allowing early response evaluation and prognostication.^{2,3}

However, in a recent study of lymph node metastases from melanoma before surgery, FDG PET had only 23% sensitivity for lymph node metastases under 5 mm, and the sensitivity increased to 83% and 100% for lymph node metastases 6 to 10 mm and over 10 mm, respectively.⁴ It can be said that the efficacy of nodal staging of melanoma