

1. Wetterhall SF. Public health preparedness for bioterrorism. *J Med Assoc Ga*. 2002;91:8-11.
2. Kirn TF. Physicians know where to turn in bioterror event. *Skin & Allergy News*. 2002;33:1-8.
3. Ramsay DL, Weary PE. Primary care in dermatology: whose role should it be? *J Am Acad Dermatol*. 1996;35:1005-1008.
4. Kohl M. Smallpox: no getting around derms. *Dermatology Times*. October 2002; 11.
5. Chen FM, Hickner J, Fink KS, Galliher JM, Burstin H. On the front lines: family physicians' preparedness for bioterrorism. *J Fam Pract*. 2002;51:745-750.

Iguana Bite-Induced Hypersensitivity Reaction

Iguanas are becoming increasingly common household pets.¹ In their natural environment iguanas are docile creatures¹; however, when provoked, especially in captivity, they exhibit defensive behaviors such as biting and scratching. "Push-ups," nodding, and head-bobbing are warning signs that may precede an attack.² Given the increasing popularity of the pet iguana, related-injuries may become more prevalent. We report a case of a hypersensitivity reaction that occurred after iguana bites.

Report of a Case. A healthy 13-year-old boy presented to our dermatology clinic 4 days after he had been bitten several times by his pet iguana. The lesions were pruritic and associated with questionable low-grade fevers. Physical examination revealed minute, violaceous-



Figure 1. Right wrist of 13-year-old boy with violaceous-pink crusted papules in the geometric shape of an iguana mouth.

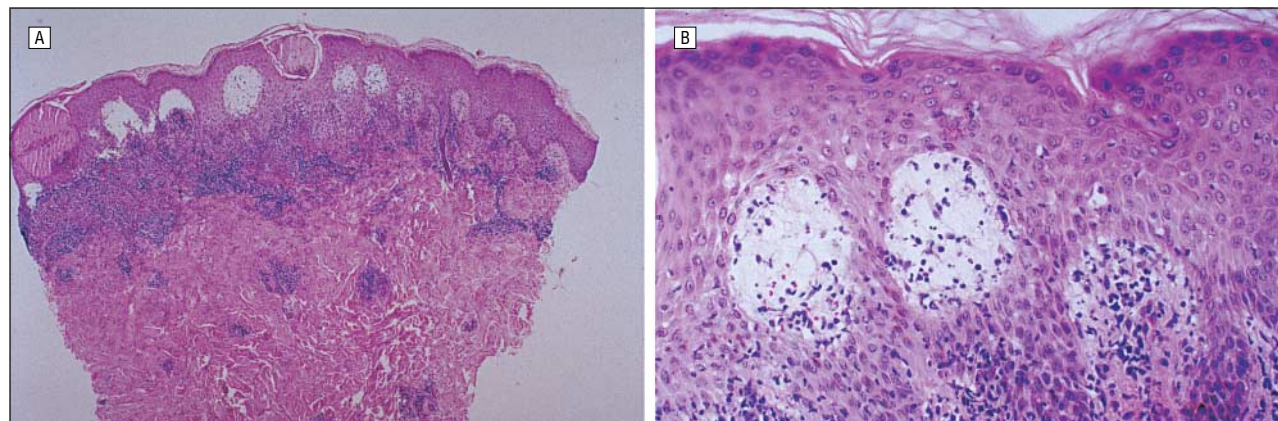


Figure 2. A, Histologic examination of the lesions demonstrated focal epidermal spongiosis and a wedge-shaped, somewhat lichenoid, perivascular and periadnexal lymphoid infiltrate, with occasional eosinophils and mast cells. B, High-power view of skin biopsy specimen demonstrating a polymorphous infiltrate (lymphocytes, eosinophils, and mast cells).

pink, crusted papules in the geometric shape of an iguana mouth on both wrists and in distinct clusters on the distal aspect of the fingers (**Figure 1**). The lesions were nontender, and there was no associated lymphadenopathy. Cultures of a skin biopsy specimen were negative for bacteria, fungi, and acid-fast bacilli. Histologic examination demonstrated focal epidermal spongiosis and a wedge-shaped, somewhat lichenoid, perivascular and periadnexal lymphoid infiltrate, with occasional eosinophils and mast cells (**Figure 2**). This dermal hypersensitivity is consistent with the pattern seen in an arthropod-bite reaction. The patient was treated with cephalexin and fluocinonide ointment, with complete resolution of his lesions within 2 weeks.

Comment. While there are several reports of injuries that have occurred after reptile bites, there are no reports of a hypersensitivity reaction resulting from an iguana bite. The shape of the bites is related to the position of the teeth in the iguana jaw.³ The injuries sustained are primarily superficial, including abrasions, lacerations, and puncture wounds, with 1 report of a deep bite wound.⁴ Bacterial inoculation of these wounds has not been reported except for 1 case of *Serratia marcescens* cellulitis following an iguana bite.⁵ Also, allergy to lizards has been documented. Two cases of allergic rhinitis and asthma were attributed to the patients' exposure to pet iguanas. Skin testing with iguana scale extracts, as well as IgE immunoassays of scale and femoral pore secretions, confirmed an allergy to iguanas.⁶

Our patient's clinical lesions appear to be unique. In contrast with reported lacerations and abrasions, the lesions of our patient were similar to an inflammatory hypersensitivity reaction. We speculate that this reaction may represent an allergic response to a component of the iguana's saliva or food (plant) sources in the iguana's mouth. Of interest were the edematous papules on the patient's hands distal to the actual bites. We theorize that this clinically eczematous eruption may represent an autoeczematization reaction ("id" reaction) to the initial bite.

Current therapeutic guidelines for reptile bites advise against antibiotic prophylaxis. However, the wound should be monitored for signs of infection. In immunocompromised patients, especially in those with bites to

the hand, foot, or face, antibiotic prophylaxis, with coverage for enteric gram-negative bacteria and anaerobes, is recommended. The patient's tetanus status should be updated as necessary. Rabies is not linked to reptile bites.⁷ We believe that these guidelines are applicable to iguana bites. If there are signs of a hypersensitivity reaction, as in our patient, the use of steroids, either topically or systemically, may be of value.

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1. Kelsey J, Ehrlich M, Henderson SO. Exotic reptile bites. *Am J Emerg Med.* 1997; 15:536-537.
2. Teitel AD. B(n)ite of the iguana. *Am J Emerg Med.* 1990;8:567-568.
3. Smith H. Iguanas. In: *Encyclopedia Americana*. Vol 14. Danbury, Conn: Grolier Inc; 1986:752-753.
4. Merin DS. Severe hand injury following a green iguana bite. *Wilderness Environ Med.* 2000;11:225-226.
5. Hsieh S. *Serratia marcescens* cellulitis following an iguana bite. *Clin Infect Dis.* 1999;28:1181-1182.
6. Kelso JM, Fox RW, Jones RT, Yunginger JW. Allergy to iguana. *J Allergy Clin Immunol.* 2000;106:369-372.
7. American Academy of Pediatrics. *Red Book: Report of the Committee on Infectious Diseases*. 25th ed. Elk Grove Village, Ill: American Academy of Pediatrics; 2000:156-159.

An Unusual Presentation of a Cutaneous Odontogenic Sinus

Facial lesions represent a large proportion of consultations to the dermatologist and the otolaryngologist. Fortunately, most of these lesions are found in typical locations, have typical morphological features, or both. Those that do present atypically can cause frustration for both patient and physician. The potential

for misdiagnosis can then lead to unnecessary procedures and suffering. We report an unusual presentation of a cutaneous odontogenic sinus in a patient who underwent several surgical procedures before the accurate diagnosis was made. This case serves as a reminder to all physicians to continually reassess atypical lesions when conservative, and more drastic, treatment protocols fail.

Report of a Case. A 42-year-old Filipino woman presented to the Primary Care Clinic at the Naval Medical Center, San Diego, Calif, in June 1996 with the chief complaint of a recurrent "sore" over the middle portion of her left nasolabial fold. The lesion had first appeared spontaneously in 1992 as an erythematous papule and had eventually evolved into a larger cystic lesion with purulent discharge. The patient reported that the lesion would partially resolve over the course of several months but recur intermittently. She noted no pain from the lesion and denied any other associated discomfort. Her medical history was unremarkable. She was eventually referred to the dermatology department for evaluation and removal of the lesion. Physical examination at that time revealed a 2 × 2-mm erythematous papule with a friable, crusted surface (**Figure 1** and **Figure 2**). The lesion was initially diagnosed as a pyogenic granuloma. A punch biopsy specimen revealed suppurative and granulomatous inflammation. The patient subsequently underwent treatment with a pulsed dye laser on 2 separate occasions, with only partial resolution. Reevaluation 4 months later demonstrated full recurrence of the lesion, with intermittent bleeding during facial movements. The patient subsequently underwent scissor excision of the lesion, during which a sinus tract was discovered just deep to the papule, extending approximately 1.5 cm into the underlying tissue. Otolaryngology consultation was obtained to rule out a possible dental abscess. The findings of computed tomography of the face and sinuses, primarily focusing on the involved area, were unremarkable. In January 1997, the otolaryngology service treated the lesion using a large elliptical excision and closing with an advancement flap. One month later, the lesion recurred. Over the course of the following year, multiple therapies, including intralesional injections of triamcino-



Figure 1. Frontal view of sinus opening, left nasal side wall.



Figure 2. Lateral view of sinus opening, left nasal side wall.