

Our patient was a healthy adult with verrucoid LV on the finger. No active internal focus of tuberculosis was detected. The dissemination was limited to six lesions and was seen as erythematous nodules and plaques over the body following an attack of enteric fever. The tuberculin was strongly positive. Histopathology from the lesion on the finger and trunk had shown sarcoid features in the absence of bacilli. Schaumann bodies are often seen in sarcoidosis but have been noted in other granulomas including tuberculosis. The presence of reticulin reflects the degree of overlap that can occur at times between tuberculosis and sarcoidosis. The fact that the patient responded well to ATT within 1 month reaffirmed our recently published observation on a large series that when confronted with a typical clinical presentation of LV in a patient showing a positive Mantoux reaction and granulomatous dermatitis on histopathology, a trial of ATT for a period not exceeding 6 weeks helps to settle the diagnosis of cutaneous tuberculosis, as definitive laboratory investigations such as culture and PCR are often not helpful or are nonconfirmatory.⁶

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References

- 1 Prosser-Thomas EW. Tuberculosis and sarcoidosis of the skin. In: Mitchell-Heggs GB, ed. *Modern Practice in Dermatology*. London: Butterworth & Co, 1960:303–24.
- 2 Sequeira JH, Ingram JT, Brain RT. Chronic bacterial infections of the skin. In: *Diseases of the Skin*. London: J & A Churchill, 1947: 472–517.
- 3 Marshall J. Tuberculosis. In: *Diseases of the Skin*. Edinburgh and London: E & L Livingstone, 1960:212–39.
- 4 Ramesh V, Misra RS, Beena KR, Mukherjee A. A study of cutaneous tuberculosis in children. *Pediatr Dermatol* 1999; **16**: 264–9.
- 5 Behl PN, Srivastava TN. Two unusual manifestations of tuberculosis of the skin with case reports. *Int J Dermatol* 1964; **10**: 85–91.
- 6 Ramam M, Mittal R, Ramesh V. How soon does cutaneous tuberculosis respond to treatment? Implications for a therapeutic test of diagnosis. *Int J Dermatol* 2004 (in press).

An unusual case of latex allergy: contact urticaria from natural rubber latex in chocolate bar wrappers

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A 19-year-old female presented with a 1-year history of intermittent lip swelling and itching occurring within minutes of biting open the wrapper of a Mars® chocolate bar. During these episodes she would also develop rhinor-

rhoea, sneezing and itchy eyes. She did not get these symptoms if her mother opened the wrapper and passed over the chocolate hence excluding the chocolate being the cause. On further questioning, she had had similar oral symptoms when blowing up balloons and drinking from certain disposable cups. She had also experienced itching and swelling of her fingers and hands within minutes of wearing rubber gloves and remembered similar symptoms when she used Copydex® glue (which contains latex) during school art classes. Eating bananas and avocado also led to itching of her mouth and lips. She was born with Vater syndrome, a condition characterized by the sporadic association of specific birth defects including vertebral, anal, cardiac, tracheo-oesophageal and renal anomalies with varying degrees of severity amongst affected individuals. Due to a congenital tracheo-oesophageal fistula, she had a number of operations as a child: tracheo-oesophageal fistula repair at 3 months and 18 months and Nissen fundoplication at the age of 2 years for treatment of gastro-oesophageal reflux. She had also been diagnosed with bronchiectasis at a young age. There was no history of atopic disease. Skin prick testing to latex (1 HEP) commercial NRL extract Soluprick® (Stallergens) resulted in a 6-mm weal. The manufacturer of the chocolate bar in question, Mars®, confirmed that they used natural rubber latex (NRL) in their cold-sealed wrapper and we believe that when using her teeth to open the wrapper, NRL must have come into contact with her lip.

This case illustrates an unusual form of exposure to NRL. Only one other case of NRL allergy to adhesive in chocolate bar wrappers has been described.¹ In that report the chocolate wrapper in question also had a coldseal, the name of the chocolate bar manufacturer was not mentioned. The adhesive material used consisted NRL and polyacrylate resins. Apart from Mars, Nestlé UK Ltd, the manufacturer of Kit Kat® also confirmed their flow wrappers are cold-sealed with a latex-based adhesive material.

Following correspondence with Mars, we understand that the company is aiming to develop a latex-free synthetic coldseal in the future. Most reports of NRL allergy are described in medical settings with exposure to rubber gloves being the most common source. The main risk factors for NRL allergy include a history of atopic disease, occupational risk such as health care workers and individuals with congenital malformations especially spina bifida due to longstanding use of indwelling urinary catheters. Our patient has Vater syndrome and it is likely that her repeated surgery in childhood resulted in increased exposure to NRL-containing healthcare products and consequent sensitization. Our patient also exhibited the well-recognized latex–fruit syndrome.^{2–5} Given that avoidance is the only treatment for latex allergy, it is important to identify unusual sources of NRL in otherwise unexplained allergic reactions. Subsequent actions can then be taken to avoid future exposure. Latex-sensitive patients

should be made aware that food packaging may be a source of NRL.

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References

- 1 Hughes TM. Natural rubber latex allergy to adhesive in chocolate bar wrappers. *Contact Dermatitis* 2001; **44**: 46–7.
- 2 Blanco C. Latex–Fruit Syndrome. *Curr Allergy Asthma Rep* 2003; **3**: 47–53.
- 3 Yagami T. Allergies to Cross-Reactive Plant Proteins. *Int Arch Allergy Immunol* 2002; **128**: 271–9.
- 4 Makinen-Kilijunen S. Banana allergy in patients with immediate hypersensitivity to natural rubber latex: characterization of cross-reacting anti-bodies and allergens. *J Allergy Clin Immunol* 1994; **93**: 990–6.
- 5 Lavaud F, Cossart C, Reiter V *et al.* Latex allergy in patients with allergy to fruit. *Lancet* 1992; **339**: 492–3.

Gottron-like papules induced by hydroxyurea

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A 70-year-old Japanese woman was referred to our clinic in May 2002 regarding an eruption on the dorsa of the hands of 2 years' duration. She had been treated for 11 years with oral hydroxyurea (HU) 1.5 g/day for polycythaemia vera. On physical examination, she had scaly erythematous papules and plaques on the dorsa of the metacarpophalangeal and interphalangeal joints of the hands. The appearance of these lesions was indistinguishable from Gottron's papules in dermatomyositis (Fig. 1). There was no evidence of muscle weakness. Laboratory tests revealed slight elevation of lactate dehydrogenase and aldolase, which were considered to be associated with polycythaemia vera. Creatine kinase was within normal limits. An antinuclear antibody test was negative. Histopathology of a skin biopsy specimen showed slight epidermal atrophy with hyperkeratosis, vacuolar changes in the basal layer, and colloid bodies in the papillary dermis. Blood vessels were dilated within the dermis, but no vasculitis was observed (Fig. 2). Direct immunofluorescence demonstrated positive staining of cytol bodies for IgM, IgA, C3 and fibrinogen.

In June 2002, HU was stopped on the suspicion that it was the cause of these *Gottron-like papules*. Instead, busulphan 2 mg/day was initiated. The cutaneous lesions gradually improved over the next few months.

HU is a cytostatic agent that has been used mainly for the treatment of myeloproliferative disorders (MPD). Dry



Figure 1 Scaly erythematous papules and plaques on the dorsa of the metacarpophalangeal and interphalangeal joints of the hands.

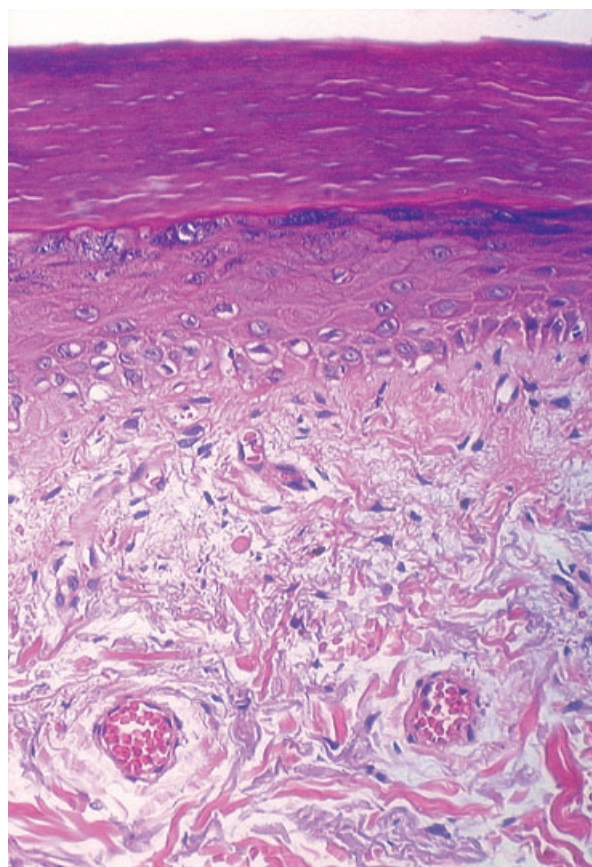


Figure 2 Hyperkeratosis, vacuolar changes in the basal layer, and dilatation of blood vessels within the dermis from a lesion on the dorsum of the hands (haematoxylin & eosin, original magnification $\times 200$).