

to excipients in the preservatives and emulsifiers series, 20 medicament allergies were found in 12 women (27%). Similar results were previously reported by other authors (3, 5).

Excluding nickel sulfate, PPD, diaminodiphenylmethane and thimerosal, which we did not consider relevant, we judged 26 positive reactions as relevant to VLSC in 12 women. We found that in such patients, topical medicaments, both their active ingredients and their excipients, were the most relevant allergens. While Lewis et al. (5) report a high % of relevance (58%), Marren et al. (4) and Goldsmith et al. (6) report 29% and 28%, respectively. Similarly, we found a % of 27% (12 positive women out of the 44 tested). Goldsmith et al. (6) stressed that more relevance was found when dermatoses involved the perianal area. The small number of cases with anal involvement in our series did not allow us to confirm or deny this. The majority of relevant allergies were found with series other than the GIRDCA standard series. Extensive patch testing of this type is particularly recommended in patients with long histories of VLSC and in non-responders to conventional treatments.

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Airborne allergic contact dermatitis from mercury in a chemistry student

PETER THOMAS, FRANZISKA RUEFF AND BERNHARD PRZYBILLA

Dermatologische Klinik und Poliklinik der Ludwig-Maximilians-Universität München, Frauenlobstrasse 9-11, D-80337 München, Germany

Key words: allergic contact dermatitis; metallic mercury; amalgam; inorganic mercury; organic mercury; cross-sensitivity; laboratory worker; occupational. © Munksgaard, 1997.

There exists continuing controversy with respect to the spectrum of clinical manifestations of mercury allergy and to the clinical interpretation of patch test reactions to mercury compounds (1).

(D2++, D3+++), thimerosal (D2-, D3++), phenylmercury borate (D2++, D3+++), phenylmercuric nitrate (D2+, D3+), amalgam (D2++, D3++) and mercury (D2++, D3++).

Case Report

A 20-year-old woman presented with acute macular erythema on the face, neck and forearms, developing into eczema over the next few days. This reaction had developed, like 2 other eruptions in previous months, on handling powdery mercury chloride compounds during a laboratory exercise that was part of her university chemistry studies. She had not had any dental fillings nor been vaccinated in recent years. There was a past history of allergic rhinoconjunctivitis from cats and house dust.

Prick testing showed immediate reactions to allergen extracts of birch pollen, house dust mites (*D. pteronyssinus*, *D. farinae*) and cat. Patch tests were performed with the European standard series, and series of preservatives, disinfectants, fragrances and metals. She showed positive reactions to mercury-(II)-amide chloride

Comment

Mercury as an allergen may be encountered in its metallic form (e.g., in amalgam-based dental fillings), as an organic compound (e.g., phenyl mercury salts) or in its inorganic form (e.g., mercury chloride compounds) (1). To mercury in amalgam fillings, allergic contact reactions have been described as stomatitis, oral lichenoid lesions or perioral facial eczema (2-4). On the other hand, patch test reactions to mercury compounds may occur without any evident clinical relevance, as reflected in ongoing discussion about thimerosal sensitisation (5-7).

This patient developed eczematous reactions on uncovered skin on airborne contact with powdery mercury chloride compounds. However, without any other identifiable exposure to mercury, particularly not to dental fillings, she showed patch test reactions to a variety of

additional test preparations containing different mercury compounds. Thus, a variety of possibly cross-reacting mercury compounds may indicate allergy to mercury. However, their individual potency of elicitation of clinical symptoms remains to be elucidated.

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Lymphomatoid contact reaction to gold earrings

C. FLEMING, D. BURDEN, M. FALLOWFIELD AND R. LEVER

Department of Dermatology, Western Infirmary, Glasgow G11 6NT, UK

Key words: lymphomatoid contact dermatitis; allergic contact dermatitis; gold earrings; gold sodium thiosulfate. © Munksgaard, 1997.

Lymphomatoid allergic contact dermatitis from gold is a rare entity characterized by nodules at sites of piercing with gold jewellery, and histological features resembling lymphocytoma cutis.

Case Report

A 34-year-old woman described painful nodules of both earlobes for 2 years. Her ears had been pierced when she was 13 years of age and she had since worn gold and platinum earrings, with occasional mild dermatitis around sites of ear piercing. She did not have gold dental fillings, and had no known therapeutic or occupational exposure to gold salts. There was no history of dermatitis on contact with jewellery at other body sites, and she was not atopic. Examination revealed tender, soft, pink nodules on both earlobes at sites of piercing, and retroauricular plaques of dermatitis.

Histological examination of shave biopsies of both nodules showed prominent dermal oedema with a diffuse dermal lymphocytic infiltrate composed predominantly of plasma cells, small lymphocytes and histiocytes. There were occasional foreign body type giant cells with a suggestion of lymphoid follicle formation.

The patient was patch tested to the European standard series and a medicaments series. She was also tested with the following gold compounds; gold sodium thiosulfate 0.5% pet., sodium aurothiomalate, gold sodium chloride, potassium dicyanoaurate, myocrisin (2% and 0.1% pet.) and gold leaf. There were positive patch tests to neomycin and gold sodium thiosulfate at D4.

6 months later, the patient was very satisfied with the cosmetic appearance of both ears following shave ex-

cision of the nodules and had not experienced any recurrence of the condition.

Discussion

"Pseudolymphomatous" reactions have a histological appearance resembling lymphocytoma cutis, with dermal lymphocytic and plasma cells forming loose lymphoid follicles. "Pseudolymphoma" is a misleading description and the term lymphomatoid is preferable. Such reactions have been described in cutaneous responses to vaccines (1), injected pollens (2), tattoos (3) and, rarely, in allergic contact dermatitis from gold (4–7). The clinical and histological features in this patient were similar to previous case reports, and the positive patch test to gold sodium thiosulfate confirmed the diagnosis of allergic contact dermatitis from gold.

Contact allergy to gold sodium thiosulfate is a subject of much recent debate (8–15). Gold contact allergy may be regarded as a spectrum, ranging from non-reacting individuals; through those with positive patch tests to gold but no history of contact dermatitis; to individuals with a clear history of contact dermatitis and positive patch tests to gold; to those with lymphomatoid responses caused by persistent dermal gold exposure or abnormal gold immunoreactivity.

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