

the soap intake, we recommended consumption of a cola beverage with the capsules.

Pica is Latin for magpie, a bird known for its wide and varied diet. While most commonly associated with pregnancy, iron deficiency is a frequent cause of this nonnutritive substance ingestion. Further investigation and treatment of this underlying deficiency in our patient was required to adequately treat her skin complaint.

This case demonstrates the importance of obtaining a good history, with a touch of serendipity.

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Allergic Contact Dermatitis After Postsurgical Repair With 2-Octylcyanoacrylate

The traditional techniques for closure of traumatic and surgical wounds (suture, staple, and adhesive tape) expanded in 1998 when the US Food and Drug Administration approved the use of 2-octylcyanoacrylate topical skin adhesive (Dermabond; Ethicon Inc, Somerville, New Jersey). This was the first commercially available cyanoacrylate tissue adhesive in the United States. Cyanoacrylates are widely used as adhesives in metal, glass, rubber, and plastic work, for example ethylcyanoacrylate (Krazy Glue; Krazy Glue, Columbus, Ohio). They are also used in dentistry and as adhesives in nail cosmesis. Although rare, cases of allergic contact dermatitis secondary to cyanoacrylate use have been reported. These cases primarily involved hairdressers, manicurists, and dental staff.¹⁻⁴ To our knowledge, we present herein the first reported case of allergic contact dermatitis in a patient with an operative repair using Dermabond.

Report of a Case. A 32-year-old healthy woman with no known allergies presented 2 weeks after an abdominoplasty for which Dermabond had been used for superficial wound closure along the lower abdomen and umbilicus. The patient noted that after 1 week, she developed a very pruritic rash at the exact locations of adhesive application (**Figure 1**). The Dermabond was removed, and within 48 hours of clobetasol use, the exanthem resolved.

Three months later, an "as is" open patch test rechallenge of the Dermabond was done on the forearm and just superior to the surgical site to assess potential allergic contact dermatitis. Two days after application, the patient developed a pruritic eczematous linear exanthem in the locations of application on the forearm and above the surgical scar (**Figure 2**). Of interest the patient also developed a "kissing" exanthem on her bicep where the 2-octylcyanoacrylate touched (Figure 2). Allergic con-



Figure 1. Note the erythematous and eczematous linearity directly over the superficial closure sites where the 2-octylcyanoacrylate was placed.



Figure 2. Itchy, not painful, linear red papules that arose 2 days after application of 2-octylcyanoacrylate on the forearm (left side) with an interesting "kissing" lesion on the bicep (right side).

tact dermatitis to 2-octylcyanoacrylate was diagnosed and documented in her medical records.

Comment. Dermabond (94% 2-octylcyanoacrylate by weight and 6% "plasticizer"), unlike sutures, does not require special instruments, anesthesia, or a removal procedure. It works rapidly and is relatively easy to use. It is the rapidity and reactivity of the cyano group of cyanoacrylate that should prevent it from being a strong sensitizer; the haptens are trapped by the keratinocytes and never reach immunomodulators. Under special conditions, however—thin skin or open wounds for example—there may be molecular penetration sufficient to act as a sensitizer. Our patient received treatment with 2-octylcyanoacrylate in a low-humidity environment (Las Vegas, Nevada), which theoretically could have caused the slow polymerization of 2-octylcyanoacrylate¹ and subsequent sensitization of the patient's immune system. Kanerva et al² discuss potential cross-sensitivity of acrylates, and thus the patient was warned about this possibility.

It is well documented that the incidence of bacitracin and neomycin contact dermatitis has increased over the years, likely attributable to their increased use and availability. As the popularity of 2-octylcyanoacrylate in-

creases in emergency departments, clinics, and operating rooms, it is important to understand the presentation of a secondary allergic contact dermatitis, in particular to compromised skin, as well as the interaction of the hap- tens and the immune system, which may increase the like- lihood of occurrence. Knowledge of this possibility and vigilant surveillance are essential to assess this poten- tial, along with separate testing of the components.

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Granulomatous Panniculitis Associated With Sjögren Syndrome

Sjögren syndrome is characterized by lymphocytic infiltrates in exocrine organs. Patients present with xerophthalmia, xerostomia, and parotid gland enlargement. Sjögren syndrome is associated with an uncom- mon but distinctive form of panniculitis. We present a case of a woman who developed a lobular granulomatous pan- niculitis associated with Sjögren syndrome.

Report of a Case. A 68-year-old woman presented with a 6-week history of tender, indurated nodules and plaques on the bilateral extensor forearms and right leg. The le- sions started as pea-sized papules and enlarged to swol- len, hot, tender plaques. She denied pruritus, trauma, or new medications. A 5-day course of cephalexin for pre- sumed cellulitis followed by a 1-week taper of predni- sone provided no relief. Medical history included hypo- thyroidism, diabetes, migraines, and endometrial cancer. Family history was significant for a sister with rheuma- toid arthritis. Review of systems revealed malaise, dry eyes, dry mouth, joint aches, and dull muscle pains.

Physical examination revealed several inflammatory nod- ules and plaques on the forearms bilaterally and on the right leg, with the most significant being a 14 × 6-cm tightly edematous, bright red, tender plaque over the left ulnar fore- arm (**Figure 1A**). A Schirmer test was performed and showed 8 mm on the left and 18 mm on the right (definite abnormal is <5 mm; definite normal is >15 mm).

Results of laboratory tests revealed a positive antinuclear antibody (1:640 with a speckled pattern), elevated eryth- rocyte sedimentation rate (58 mm/h), elevated aspartate aminotransferase level (47 U/L), and trace protein in the



Figure 1. Patient's left forearm. A, Erythematous indurated plaque 7 days after intralesional steroid injection. B, Complete resolution after 2 months of treatment with colchicine.

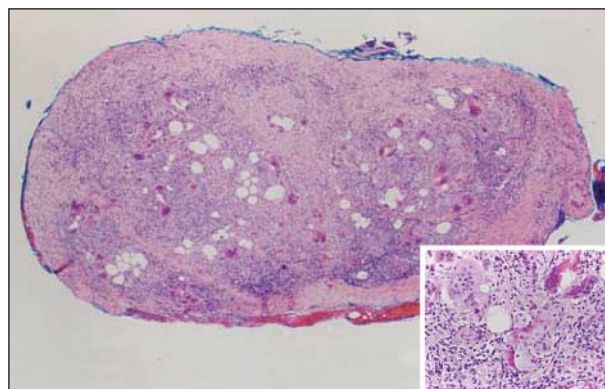


Figure 2. Histologic examination with hematoxylin-eosin reveals inflammation in the subcutaneous fat (larger photograph, original magnification ×4) multinucleated giant cells and lymphohistiocytic infiltrate (inset, original magnification ×20).

urine. Test results for rheumatoid factor, renal function, complete blood cell count, and extractable nuclear anti- gen screening panel were all within normal limits.

A punch biopsy of affected skin was performed. Histo- logic analysis of the skin specimen revealed an unremark- able epidermis and a mild interstitial lymphohistiocytic in- filtrate in the dermis. There was a mixed lobular and septal granulomatous panniculitis with numerous multinucle- ated giant cells (**Figure 2**, inset). No foreign body was iden- tified through polarized light. Acid-fast and methenamine silver stains proved negative for organisms.

Analysis of a minor salivary gland biopsy specimen revealed significant lymphocytic foci, lobular glandular atrophy, and increased intralobular fat. The diagnosis of Sjögren syndrome was based on Schirmer test findings, xerophthalmia, xerostomia, and findings of the salivary gland biopsy.