

requiring hysterectomy by 30 years of age.² More importantly, individuals with HLRCC syndrome have an increased propensity for the development of type II papillary renal cell carcinoma, a very aggressive form of cancer that tends to be asymptomatic until advanced, occurring in 1–30% of affected patients.^{3,4}

Recommended screening tests for patients with multiple cutaneous leiomyoma and follow-up of patients with confirmed syndrome are shown in Table 1.³ When few lesions are present, the best treatment is surgical excision. Good results have been reported with cryotherapy, electrocoagulation, carbon dioxide laser ablation and, recently, botulinum toxin. Other pharmaceutical drugs such as nitroglycerin or gabapentin have limited effectiveness.^{4,5}

In conclusion, we report a patient presenting at a young age with HLRCC. Early detection of cutaneous lesions and requesting appropriate complementary tests are essential, regardless of age, as this can lead to an improved prognosis in these patients.

D. Romero-Pérez,¹ B. Encabo-Durán,¹ M. Blanes-Martínez,¹ and M. Niverio-de Jaime²

Departments of ¹Dermatology and ²Pathology, University General Hospital of Alicante, Pintor Baeza 12, 03010, Alicante, Spain

E-mail: davidromero66@hotmail.com

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Seabather's eruption caused by the thimble jellyfish (*Linuche aquila*) in the Philippines

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We describe the clinicopathological features of seabather's eruption (SBE) caused by the thimble jellyfish, *Linuche aquila*. During seasonal outbreaks, this jellyfish is found mostly in the coastal waters of the Philippines. Its prevalence has been increasing in recent years, affecting mostly tourists and triathletes. We report an outbreak of seabather's eruption in three male swimmers.

Three adult male patients presented with intensely pruritic erythematous papules on the chest and trunk, which had appeared 8 h after they had partaken in a triathlon swim along the coastal waters of Davao Gulf in the Philippines.

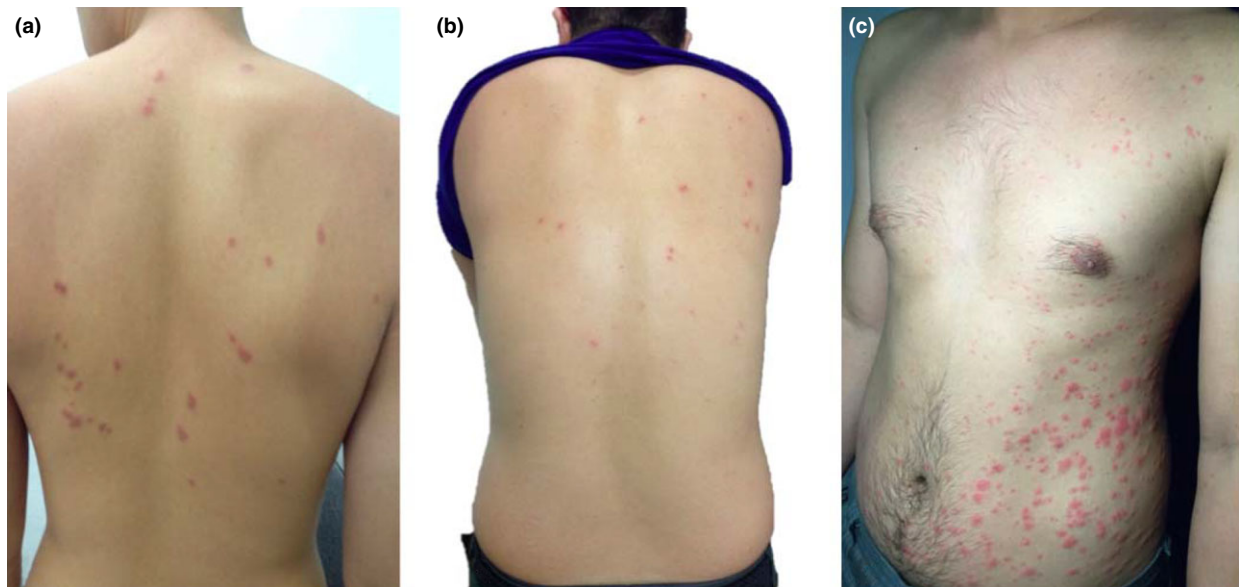


Figure 1 Erythematous papules on covered areas from the three patients: (a,b) back and (c) trunk.

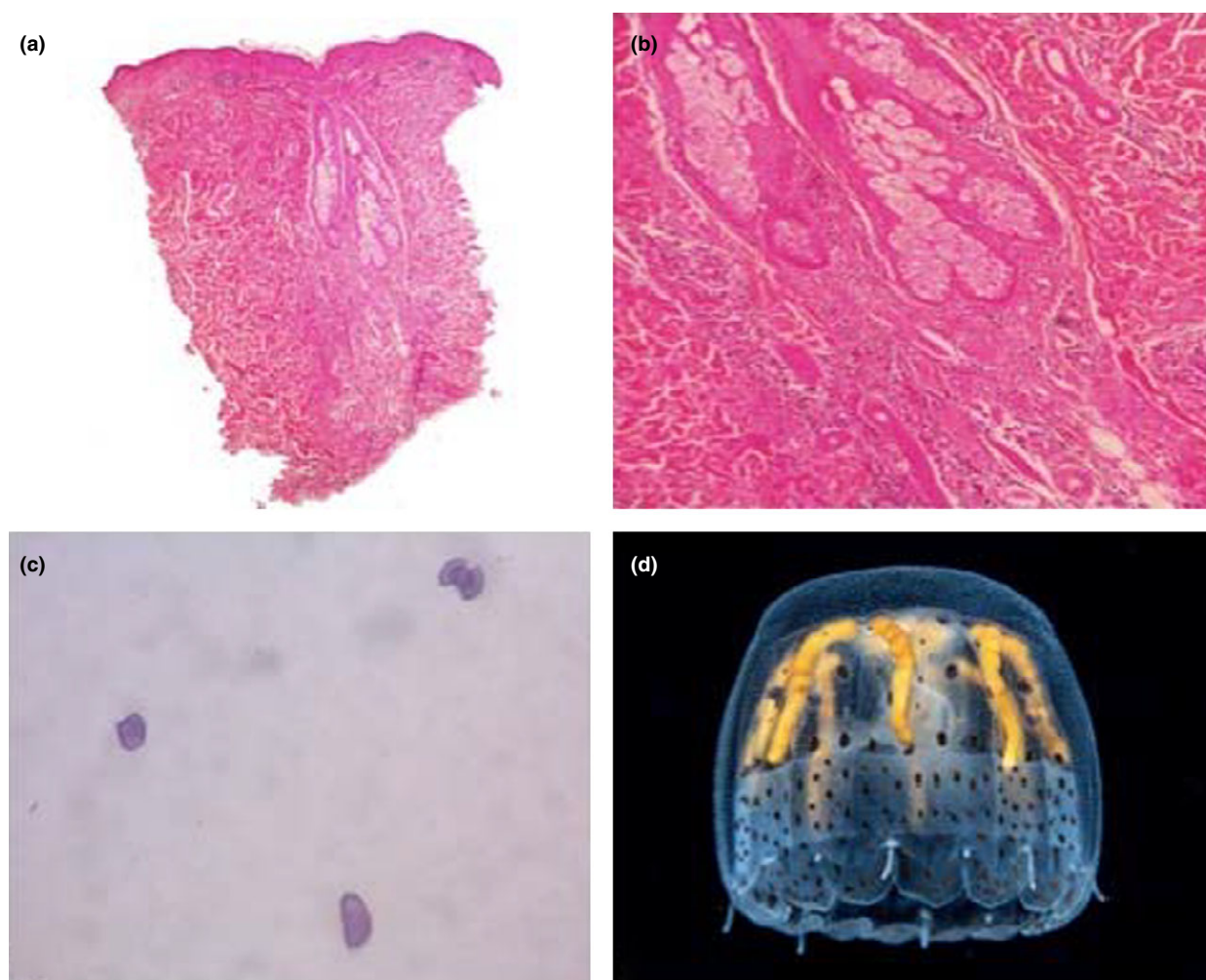


Figure 2 (a) Skin punch biopsy of an erythematous papule from the first patient revealed superficial and deep perivascular, interstitial and periadnexal infiltrates consisting predominantly of lymphocytes, few eosinophils and neutrophils (haematoxylin and eosin, original magnification $\times 40$; (b) $\times 100$. (c) Multiple ciliated, solid-bodied planula or larval forms of a cnidarian (haematoxylin only, original magnification $\times 100$). (d) Adult thimble jellyfish, *Linuche aquila* (used with kind permission of Scott Tuason).

On physical examination, the patients were found to have urticarial and vesicular papules scattered over the chest and back, which were the areas covered by a triathlon suit during their swim (Fig. 1). One of the patients also experienced flu-like symptoms.

Histological examination of a skin biopsy from one patient revealed moderately dense superficial and deep interstitial, perivascular and periadnexal inflammatory infiltrates consisting predominantly of lymphocytes and a few eosinophils and neutrophils (Fig. 2a,b).

Microscopic examination of the seawater by a marine biologist identified multiple planulae or larval forms of cnidarians and adult forms of *L. aquila* (Fig. 2c,d). All patients were treated with oral and topical corticosteroids and oral antihistamines, which resulted in complete remission after 7 days.

Seabather's eruption is characterized by intensely pruritic erythematous papules that appear within 24 h after exposure to seawater, which is a hypersensitivity reaction to the content of the nematocysts of the cnidarians.¹ The disease is caused by the planulae of the thimble jellyfish (*L. aquila* and *Linuche unguiculata*), larvae of the sea anemone *Edwardsiella lineata* or larvae of the other cnidarians that can be found mostly in tropical coastal waters.² Cutaneous manifestations appear on areas covered by swimwear when the larval and adult forms of the cnidarians are trapped under the swimwear and discharge nematocysts under mechanical pressure. Discharge from the stinging cells also occur when the victim washes the body with fresh water as this causes osmosis of the contents of the nematocysts.³

Seabather's eruption occurs commonly in coastal tropical waters such as in the Philippines and other parts of southeast Asia, which in recent years have become popular tourist destinations.⁴ The lesions commonly present as intensely pruritic erythematous papules, but can occur as severe envenomation leading to flu-like symptoms.⁵ The lesions occur in areas covered by swimwear, as the planula larvae of *L. unguiculata* and *L. aquila* are small enough to be trapped inside the fabric. The eruption needs to be distinguished from cercarial dermatitis or swimmer's itch, which is caused by *Schistosoma cercariae*, which can be found in either fresh water or seawater, and presents as pruritic erythematous papules limited to exposed areas of the body.² Other differential diagnoses include pseudomonas folliculitis, arthropod bites, scabies and cold/aquagenic urticaria. In contrast to urticarial lesions, the lesions of SBE are limited to covered areas and persist for days.

The disease usually runs a benign course, and the treatment is symptomatic using oral antihistamines and topical steroids. In some cases however, severe envenomation may result in febrile episodes and extensive lesions, which require a short course of oral glucocorticosteroids.⁴ Important precautionary measures for the travellers include removal of swimwear before showering, as fresh water causes discharge of the entrapped planula. The swimwear itself should also be rinsed with soap and water and then heat-dried because the eruptions can recur if it is only air-dried. Finally, highly sensitized individuals should avoid swimming in infested waters during seasonal outbreaks.²

B. E. K. Guevara,¹ J. F. Dayrit,² and V. Haddad Jr³

¹Department of Dermatology, Southern Philippines Medical Center, Bajada Davao City, 8000, Philippines; ²Department of Internal Medicine, De La Salle Health Sciences Institute, Dasmariñas City, Philippines; and ³Department of Dermatology, Botucatu Medical School, São Paulo State University, São Paulo, Brazil
E-mail: bry0529@yahoo.com

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