The most frequent site of metastasis is regional lymph nodes (40-83%), followed by lung (35-53%), bone (20-28%) and skin (10-17%), with equal frequency of lymphatic and hematogenous forms. Although the prognosis of metastatic BCC is extremely poor, our patient remains alive with no subjective symptoms 14 months after the detection of metastatic lesions.

In conclusion, it is important for dermatologists to be aware of the possibility of metastasis in BCCs, although the incidence is very low. Especially, patients with BCC showing large size or aggressive histopathology including morphea form, infiltrative and basosquamous types, should be appropriately treated and followed up.

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A case of hydroxychloroquine induced pruritus

Hydroxychloroquine is an antimalarial drug often used in dermatology for the management of several disorders, particularly in the management of collagenoses. Several dermatological side effects of hydroxychloroquine have been reported [1, 2]. Pruritus associated with hydroxychloroquine treatment has rarely been reported. To our knowledge only two cases of pruritus associated with hydroxychloroquine treatment exist [1, 3]. We report a woman with discoid lupus erythematosus who had been treated by hydroxychloroquine and developed generalized pruritus.

Figure 1. Excoriations on the lower extremities

Case report

A 36-year-old Caucasian woman attended our clinic with 3-4 mm sized erythematous papular lesions with desquamation on her face for 1.5 years which was consistent with discoid lupus erythematosus. Routine laboratory tests were normal and no evidence of systemic manifestations of lupus erythematosus was found. 400 mg daily hydroxychloroquine therapy was started. 10 days after the initiation of therapy, pruritus all over her body which the patient described as a generalized itch and biting sensation occurred. Pruritus was continuous throughout the day and its intensity was 9 according to the visual analog scale (from 0 to10).

On physical examination there were excoriations on her body especially on her extremities (figure 1). As no possible cause of pruritus was detected on detailed examination and the only medication the patient had been receiving was hydroxychloroquine, pruritus secondary to medication was considered and hydroxychloroquine treatment was stopped three days after the pruritus started. The patient’s pruritus resolved spontaneously in one week after discontinuation of hydroxychloroquine therapy and the excoriations subsided in 10 days after the cessation of pruritus. Two months later the patient experienced a flare-up of the discoid lupus erythematosus lesions and hydroxychloroquine therapy was started again. The patient experienced severe pruritus one week after the initiation of the therapy and hydroxychloroquine treatment was stopped; her pruritus resolved in one week.

Discussion

Hydroxychloroquine is a derivative of chloroquine which has been used successfully in the treatment of discoid lupus erythematosus. It is a well-tolerated drug with fewer side effects compared to chloroquine. However, it is important to be aware of possible side effects such as pruritus which can occur in association with the medication. The mechanism of pruritus induced by hydroxychloroquine is not fully understood, but it is believed to be related to the inhibition of serotonin synthesis or release.

Figure 1. Excoriations on the lower extremities
lupus erythematosus [1, 2]. Pruritus has been reported frequently in Africans and less frequently in Caucasian and Asian patients using chloroquine treatment for malaria [4]. It has been suggested that opiate receptors and/or endogenous opioids may be involved in chloroquine-induced pruritus in malaria fever as μ-opiate receptor antagonists and kappa-opioid agonists reduce the severity of chloroquine-induced pruritus [5, 6]. Aquagenic-type pruritus, in Caucasian patients treated with chloroquine for rheumatological diseases has also been reported [2].

Generalized pruritus is very rarely reported in patients treated with hydroxychloroquine. Holme et al. reported a Caucasian woman with systemic lupus erythematosus treated with hydroxychloroquine who described a three-year history of severe generalized pruritus unresponsive to antihistamine therapy. Her symptoms resolved rapidly when hydroxychloroquine treatment was discontinued and the itching returned within four weeks with the re-use of hydroxychloroquine [1]. Fain et al. reported a woman of Tunisian origin with systemic lupus erythematosus who developed severe pruritus two months after starting hydroxychloroquine therapy and whose symptoms resolved one month following the withdrawal of hydroxychloroquine and recurred two weeks after its subsequent reintroduction [3]. Alonso et al. also reported pruritus in four patients with lupus receiving hydroxychloroquine treatment, but this was aquagenic-type pruritus [2].

We think that our patient’s pruritus was associated with hydroxychloroquine therapy because no other possible etiologic factor was found for the presence of pruritus in detailed examination and her pruritus started 10 days after the initiation of hydroxychloroquine therapy and resolved in 1 week after its discontinuation. Also recurrence following the re-use of hydroxychloroquine was observed.

Though pruritus associated with hydroxychloroquine treatment is a very rare side effect, practitioners should be aware of it as it can be very severe and may affect the compliance with the treatment.

Vulvar lymphangiectases mimicking genital warts in female genital mutilation

With the increase in immigration into Europe it is possible to observe particular anatomical and pathological conditions related to cultural habits quite common in the countries of origin of these patients but little known to our health practitioners, a situation which may lead to physical and psychic consequences, at times quite serious.

There are many immediate and late complications to which women are exposed in female genital mutilation (FGM), in view of the absolute absence of asepsis, of the rudimentary techniques of incision and suture, of the use of unsuitable instruments and of the inadequacy of materials used for dressing and cicatrization. One of these is abnormal cicatrization, including the formation of keloid scars [1].

A 25-year-old Somali woman of Afghan origin, in Italy for about two years, came for medical examination complaining of papular lesions of a verrucous aspect, extremely itchy, localized in the vulvar region, with moderate local lymphoedema (figure 1A). A more careful examination showed evidence of complete disruption of the genital anatomy and absence of the normal anatomical structures which were replaced by scar tissue. In childhood, the patient had undergone FGM involving clitordectomy, excision of labia minora and labia majora and reapproximation of remnant labia majora (so called infibulation). No abnormalities were observed in regard to the lower limbs.

These lesions had been previously diagnosed, at another hospital, as genital condylomata, and had been treated over a long period of time, about one year, by means of cryotherapy with liquid nitrogen, without improvement. Histological examination of a biopsy specimen from one of the verrucous formations of the right labium majus showed an acanthotic and hyperkeratotic epidermis, with presence, in the papillary dermis, of cavities of a lymphatic type, lined with mononstratified endothelium, containing fibrinoid material and mononucleated cells. The epithelium above these cavities appeared spongiotic with parakeratosis (figure 1B). Moreover, the surrounding dermis showed thickened collagen bundles, an increase in the number of capillaries and a mild perivascular lymphoplasmacellular infiltrate. No viropathic effects or granulomatous lesions were noticed. The histological picture appeared therefore to be consistent with a diagnosis of lymphangiectasis, in the context of a skin affected by lichenification, presumably caused by intense scratching.

Acquired lymphangiectases are indistinguishable from congenital superficial lymphangioma (circumscribed lymphangiomata) except for the age of onset and for the cause, secondary to damage of previously normal lymphatic channels or due to lymphatic vessel malformation, respectively. The clinical aspect is in the form of translucent vesicles described as “frogspawn” in case of extra-genital lymphangiectases, while the vulvar lymphangiomas may sometimes look like verrucous papules which can mimic genital warts [2, 3]. Many are the conditions associated with acquired lymphangiectases reported in the literature [4]: they include acquired lymphoedema due to various causes (filarisis, sexually transmitted infections, tuberculosis), cryspelias, Cohn’s disease, surgical or radiotherapeutic procedures, traumas, keloids, scleroderma, dermatopathies due to penicillamine or to corticosteroids,

References: