reported in 2000, 149 in 2001, 115 in 2002, 122 in 2003, 91 in 2004 and 99 in 2005. Although the increase from 91 to 99 cases from 2004 to 2005 was not statistically significant, it is worth noting that it was linked to a syphilis outbreak that occurred in 2005 among MSM. Indeed, from 2000 and 2005, the proportion of syphilis cases involving MSM increased (p < 0.001), while that involving females and heterosexual men decreased and remained stable, respectively (figure 1). Of the 767 syphilis cases with HIV status data, 136 (17.3%) were HIV-positive, including 51 patients who received their HIV and syphilis diagnoses concurrently and 85 who had previously been diagnosed as HIV-positive. HIV prevalence was 43.3% in MSM, 11.3% in heterosexual men, and 10.8% in females. There was a general increase in the number of HIV-positive patients in Portugal after 2002 (p < 0.001).

The Sentinel Network data indicate a selective increase in syphilis infections in MSM since 2000, while the number of heterosexually transmitted cases remained relatively stable. However, the proportion of heterosexually transmitted cases was relatively large for Western Europe. The frequent occurrence of syphilis and HIV co-infection is of great concern; these patients are also at risk for gonorrhea, chlamydia infections and L2 chlamydia proctitis [2-4]. Media coverage, syphilis-awareness advertisements in the gay media and distribution of literature to the homosexual community are evidently insufficient to contain syphilis spreading among MSM in Portugal.

In conclusion, there has been a surge in syphilis rates in many Western countries since the late 1990s. However, this trend only emerged in Portugal the past few years. This review of syphilis cases between 2000 and 2005 shows similar findings to epidemiological trends in other European countries. Syphilis screening should be emphasized for MSM, especially for those being treated for HIV.

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Ruscus aculeatus L. is a member of the Liliaceae family and is native to Mediterranean Europe and Africa. It has been widely used as a laxative and diuretic agent and as a vasoconstrictor in the topical treatment of varices and haemorrhoids. The pharmacological activity of Ruscus aculeatus L. is attributed to steroidal saponins, mainly ruscogenin (figure 1) and neoruscogenin, which have vasoconstricting and anti-inflammatory effects [1, 2].

A 35-year-old man presented with pruritic erythematous lesions on the perianal area and buttocks 5 days after initiating the local application of Ruscus Llorens® (Llorens, Barcelona, Spain) cream for haemorrhoids. The lesions became papulo-erythematous, well-defined and spread within a day to the trunk and both legs. The patient had used other antihaemorrhoidal creams previously with no cutaneous reactions. Therapy with the cream was stopped and the patient was successfully treated with oral corticosteroids.

The antihaemorrhoidal cream contained ruscogenin, cinchocaine hydrochloride (dibucaine), prednisolone, menthol, zinc oxide and other excipients in its composition. The patient was patch tested with GEIDAC (Spanish Group of Investigation of Contact Dermatitis) standard series, local anaesthetics series and Ruscus llorens® patch tests were positive (++) at 48 and 96 hours, and tetracaine (++) and lidocaine (+) at 96 hours.

**Figure 1.** Chemical structure of ruscogenin.
One month later patch testing with Ruscus llorens® cream and with separate ingredients of the cream that were provided by the commercial laboratory was performed, showing positive (+++) results for ruscogenin 1% pet, cinchocaine 5% pet and Ruscus llorens® cream as is at 48 and 96 h. Further tests with corticosteroid series produced positive reactions (+) to hydrocortisone and hydrocortisone acetate at 7 days but negative to prednisolone (contained in Ruscus llorens® cream). Patch tests with ruscogenin 1% pet were negative in five controls.

Patients with haemorrhoids apply multiple topical drugs and allergic contact dermatitis is frequently observed in these patients. Local anaesthetics are, by far, the most common allergens but other topical medications may cause sensitization too [3]. On the basis of structural similarities, local anaesthetics are divided into esters and amides. Our patient reacted to cinchocaine and lidocaine which are amides but also to a member of the ester group, tetracaine. Ester local anaesthetics are common causes of contact sensitization and cross-reactivity within the ester group is well known [3, 4]. However, multiple sensitivities to local anaesthetics cannot be predicted only on the basis of structural groups. Patients reacting to more than one anaesthetic may react to both groups [4].

Cinchocaine had been considered a rare cause of contact sensitization but some studies have reported that allergy to cinchocaine is most prevalent after benzocaïne [4]. The differences reported may be due to variations in the use of cinchocaine in different countries.

Positive patch tests to tixocortol pivalate, hydrocortisone and hydrocortisone acetate suggested type A corticosteroid sensitization in our case. We cannot explain the negative result to the prednisolone patch test. A false negative reaction or previously unknown sensitizations are possible explanations.

Ruscogenin has been considered to be safe and lists no contraindications. Contact dermatitis has been previously reported in two patients topically exposed to ruscogenin (contained in anti-haemorrhoidal cream [5] and in anti-cellulitis cream [6]). Patch tests in healthy controls have been reported negative and ruscogenin has been considered non irritant on patch testing. Ruscogenin can be contained in numerous topical preparations such as antihaemorrhoidal creams, cosmetic products for application to the skin, after shave and after depilation products. Although contact dermatitis to ruscogenin is a rare event to date, it is probably underreported. We emphasize the importance of taking it into account.

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**Treatment of lymph node metastatic melanoma with carbon ion radiotherapy**

A 31-year-old Japanese man noticed a hemorrhagic black nodule on his right thigh and underwent surgical excision in January 2005. Histopathology showed a melanoma with negative margin (tumor thickness 9 mm) and he was referred to our clinic for additional treatment.

Although most laboratory tests were within normal ranges, serum LDH level was slightly high. Computed tomography scanning revealed a right inguinal lymph node swelling, 3 cm in diameter. Extended excision and right inguinal node dissection were performed in February 2005. On the basis of the above findings, this case was allocated to pT4bN3M0 (Stage IIC) by the AJCC/UICC classification system (2002).

After the operation, although he was given multi-agent chemotherapy (dacarbazine, nimustine and vincristine) and immune therapy (interferon-beta) in six courses, following the Japanese guidelines for treatment of melanoma, he had a retroperitoneal node metastasis in September. Lymph node dissection was performed again and he received outpatient immune therapy afterwards. In January 2006, he had an external iliac node metastasis. At that time, neither distant metastasis by imaging test nor abnormal serum findings including LDH and 5-S-cysteinyldopa were recognized. Therefore, carbon ion radiotherapy was chosen because he did not have complete remission either after past operations or after chemotherapy.

A total of 64 Gray equivalent dose of carbon ion radiotherapy was given to an external iliac node metastasis in April 2006. The metastasis, 62 × 30 mm in size, was reduced with internal necrosis after six months (figures 1A, B). After one year, the tumor was reduced by more than 50%, to 36 × 26 mm (figure 1C). Since then he had a left cervical node metastasis in July and a mediastinal node metastasis in October 2006. Although additional carbon ion radiotherapy succeeded in local control each time, systemic metastasis developed. In spite of further multi-agent chemotherapy, he died in September 2007.

Carbon ion radiotherapy is superior to conventional photon therapy such as X-rays and γ-rays in several aspects [1-3]. As a physical advantage, carbon ion radiotherapy has a high linear energy transfer and has outstanding dose localization properties. It shows an increase in energy deposition with penetration depth up to a sharp maximum at the end of its range. Dose escalation can be performed without toxicity in surrounding normal tissues.