which was confirmed by polymerase chain reaction (PCR; 1,200 copy/mL).
Two months later, the clinical examination of the eight-month-old boy was normal. Anti-CMV IgG were detected but anti-HSV and anti-VZV antibodies were not present, and PCR blood test for enterovirus was negative. The mother was CMV IgG seropositive but was negative before her pregnancy. No immune deficiency was found. The complete blood count was normal with no Howell-Jolly body. Lymphocyte immunophenotyping and testing for quantitative immunoglobulin including total IgE, chemotaxis of polynuclear neutrophils, and complement component were normal. Natural IgG anti-A antibodies were negative.
The diagnosis of KVE is mainly based on clinical history of AD and specific umbilicated erythematous vesicles. The culture and PCR leads to identification of the virus, most commonly HSV. It was thus unexpected in our case to detect CMV and not HSV as anticipated. To our knowledge, no previous case of KVE due to CMV has been reported [1, 2]. Although vesicles were positive for CMV based on both culture and PCR, HSV- and other virus-related KVE could not be formally excluded since cutaneous PCR for these viruses was not performed. However, the absence of anti-HSV and anti-VZV IgG and the absence of enterovirus DNA in blood makes this hypothesis unlikely.
A CMV primary infection should also be discussed as suggested by the presence of hard palate erosion [1]. However, KVE can also be associated with viremia and involvement of the lungs, liver, brain, gastrointestinal tract and mucosa [3]. Furthermore, based on the unaffected skin with regards to vesicles which involved only pre-existing sites of atopic dermatitis, a CMV superinfection of pre-existing AD seems more likely.
Recently, Drozd *et al*. [1] analysed 53 cases of cutaneous CMV. Manifestations were polymorphous including morbilliform rash, petechiae, purpura, plaques, vesicles, bullae, erosions, erythema, papules, oedema, vasculitis, and pustules. However, ulcers, mainly mucosal, were the most reported lesion. Systemic manifestations of CMV have been described including pneumonitis, gastrointestinal, retinitis, hepatitis and aseptic meningitis [2]. It should be noted that our child presented with intestinal and pulmonary symptoms before the occurrence of cutaneous lesions in association with the presence of anti-CMV IgG. We can thus hypothesize a primary systemic CMV infection as suggested by the CMV seroconversion of his mother during pregnancy or soon after childbirth, followed by a delayed cutaneous infection. The transplacental transfer of maternal anti-CMV IgG to the child can indeed be excluded at eight months of age.
Although valganciclovir or ganciclovir are mainly used in the literature to treat cutaneous CMV manifestations [1], acyclovir was successfully used in our experience. Acyclovir is a guanosine-analogue with activity against a range of herpesviruses. It is particularly active against herpes simplex virus-1 and -2, but also has some activity against CMV [4, 5].
KVE should be added to the list of less common dermatological presentations of CMV infection. ■

Disclosure. *Conflicts of interest: none. Acknowledgements: The authors thank Elisabeth Homassel for her technical assistance.*

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doi:10.1684/ejd.2019.3630

Ultrasonography and Doppler in patients with psoriasis and psoriatic arthritis

Psoriasis (Pso) is one of the most common dermatological inflammatory conditions, with an estimated prevalence of 2-3%. Pso is related to a form of spondyloarthritis called "psoriatic arthritis" (PsoA); PsoA prevalence in patients with psoriasis ranges from 5 to 42%, depending on the population studied [1-3].
This study was designed to establish an epidemiological and ultrasonographic profile using colour Doppler ultrasound in patients with psoriasis and/or subclinical and clinical psoriatic arthritis to determine the Kappa index among observers and the most frequent ultrasound findings.
A case-control study was performed between December 2015 and December 2016 involving 144 patients with Pso and/or PsoA and 24 controls (AAE: 89054418.8.0000.5078) (*table I*).
The vast majority (95.8%) of the patients in the case group were negative for rheumatoid factor; 90.3% of the group had a clinical picture of cutaneous psoriasis, which was a mild to severe condition, and 39.8% had a diagnosis of psoriatic arthritis. However, 77.8% of these patients showed signs of enthesitis on ultrasound examination according to the MASEI criteria and 65.3% had clinical signs of nail psoriasis, such as pitting, onycholysis, nail hyperkeratosis, *etc*. on any of the 20 fingers or toes. In the control group, signs of nail psoriasis were reported in 35.4% of the 24 controls.
The MASEI scores ranged from 0 to 52, with a mean of 14.72 and a standard deviation of 11.60 (81 patients had MASEI scores $\geq$20, representing 55.5%). The major-

Table 1. Distribution of patients with psoriasis and psoriatic arthritis.

Feature	Case (*n* = 144)	Control (*n* = 24)	*p*
Age (mean/SD) years	50.13 (13.62)	46.17 (14.30)	0.192
BMI (mean/SD) 25 a <30 (*n*/%)	28.14 (5.44) 62 (43.05)	27.44 (6.77) 10 (41.66)	0.574
PASI (mean/SD) <10 (*n*/%) ≥10 (*n*/%)	5.34 (6.03) 125 (86.81) 19 (13,19)	N/A	N/A
PEST (mean/SD) ≥3 (*n*/%)	2.21 (1.66) 52 (36.11)	N/A	N/A
DLQI (mean/SD) ≥10 (*n*/%)	4.39 (5.16) 22 (15.27)	N/A	N/A
CASPAR (mean/SD) ≥3 (*n*/%)	4.31 (1.05) 120 (83.33)	N/A	N/A
Duration of symptoms (mean/SD)	16.67 (12.29)	N/A	N/A

BMI: body mass index; PASI: Psoriasis Area and Severity Index; PEST: Psoriasis Epidemiology Screening Tool; DLQI: Dermatology Life Quality Index; CASPAR: classification criteria for psoriatic arthritis.

ity of patients were women, representing 57.63% (83 female patients) of the case group. In the 1,728 total entheses evaluated in the case group, thickening was the most common ultrasound finding, identified in 29.1% of patients, followed by alteration of tendon ecotexture (structure) in 27.3%, calcification in 21.6%, bursitis in 16.5%, positive Doppler power signals in 7.2%, and erosion in 2.8%.

Of the 1,728 entheses that were evaluated by ultrasound, 1,143 (66.14%) showed at least one signal indicative of enthesopathy. The most affected joint corresponded to thickening of the calcaneus tendon (165/288; 57.3%), followed by thickening of the plantar fasciae (151/288; 52.4%), the distal patellar tendon (288; 20.5%), triceps (55/288; 19.1%), quadriceps (53/288; 18.4%), and finally, the proximal patellar tendon (6.9%).

In the PsoA framework, it is possible to evaluate types of injuries and the degree of injury. Doppler is an indicative signal of an inflammatory process in evaluated entheses of the body, according to the ultrasound criteria for MASEI, and should be incorporated into the standard evaluation protocol for patients in order to provide better follow-up. The epidemiological profile of patients with psoriasis and/or subclinical and clinical psoriatic arthritis reveals overweight women with a mean age of 50 years who have a disease duration of more than 15 years, controlled disease, and who are treated with topical medications and methotrexate. The majority of patients were negative for rheumatoid factor, with controlled cutaneous psoriasis, and 39.8% had a diagnosis of psoriatic arthritis and a reduction in quality of life. ■

Disclosure. *Financial support: none. Conflicts of interest: none.*

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doi:10.1684/ejd.2019.3583

Periorbital xanthoma-like amyloidosis in a patient with multiple myeloma-associated systemic amyloidosis

A 77-year-old woman was referred to our hospital, complaining of a number of petechiae and periorbital soft, flat-elevated yellowish plaques (*figure 1A*). Detailed clinical examination revealed a skin-coloured mass around the anus (*figure 1B*). Macroglossia was not observed. A biopsy specimen from the upper eyelid showed dense deposition of amorphous materials in the dermis (*figure 1C*), which was positively stained by Congo-red and Dylon stain (*figure 1D, E*). Xanthoma cells were not detected. Another biopsy specimen from the anus also showed amyloid deposits, which was confirmed by Congo-red and Dylon stain. Immunohistologically, the dermal deposits reacted positively to antibodies against immunoglobulin (Ig) λ light chain (IgLλ), but negatively to IgLκ. Laboratory examination showed $4.2\times10^3/\mu$L leukocytes (27% of which were lymphocytes without atypical lymphocytes), 817 mg/dL IgG (normal: 870-1700), 118 mg/dL IgA (110-410), and 61 mg/dL IgM (85-220). Serum electrophoresis revealed M-protein (λ-type), and Bence-Jones proteins (λ-type M protein) were detected in the urine. Bone marrow biopsy revealed a diffuse infiltration of predominantly small-to-