multiple organ systems, with pulmonary hypertension being a major cause of death. 1

The diagnosis of MCTD can be clinically challenging, as symptoms of the disease commonly evolve over time. In fact, it can be several years before enough overlapping symptoms are present to suspect the diagnosis. 1 The Alarcon-Segovia criteria are widely regarded as the best criteria for MCTD. 2 Using this measure, the patient in this case clearly meets the diagnostic criteria for MCTD, demonstrating both the required serologic evidence of disease (elevated anti-U1-RNP titer $\geq 1:1600$) as well as 5 of the 5 clinical criteria (Raynaud’s phenomenon, edema of the hands, synovitis, myositis, and acrosclerosis).

Cutaneous manifestations are common in patients with MCTD, with Raynaud’s phenomenon being the most common skin change, especially early in the disease course. 3 Other prominent cutaneous manifestations of MCTD include swelling of the fingers, complete hand edema, and skin changes classically associated with SLE, including a malar rash. 1 In this case, the patient developed nodules on her abdomen and arms, which histologically were diagnostic of lipomembranous panniculitis. 4 Whereas this condition has been most commonly associated with vascular insufficiency, it has also been reported in several connective tissue disorders, such as panniculitis associated with dermatomyositis, lupus profundus, morphea, and systemic sclerosis. 4 To date no treatments have been found to be particularly effective, either for this patient or in the literature.

Only a single well-characterized case of cutaneous panniculitis in MCTD has been reported previously in the literature. 5 The clinical and histologic picture of that case, however, may have been more consistent with a diagnosis of lipodermatosclerosis, rather than pure panniculitis. The numerous non-inflammatory subcutaneous plaques, as well as the histologic changes of lipomembranous fat necrosis, represent the first report of panniculitis as a manifestation of MCTD.

In summary, we report a case of lipomembranous panniculitis occurring in the unusual setting of MCTD. Accordingly, although rare, panniculitis should be regarded as a possible cutaneous manifestation of MCTD. When a subcutaneous disease is suspected in patients with MCTD, tissue biopsy, preferably a deep excisional specimen to include subcutaneous fat, is recommended for accurate evaluation of the presence of panniculitis and/or fat necrosis in these patients.

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Introducing the delayed retinoid burn: A case report and discussion of this potential risk of retinoid-phototherapy combination management

To the Editor: Combination treatment with an oral retinoid and phototherapy, including narrowband UVB (NB-UVB) and PUVA, is highly effective in psoriasis. 1, 2 However, there is a unique risk for phototoxicity when a systemic retinoid is added to an already maximized phototherapy dosimetry. We have encountered this phenomenon many times over the years to the extent that a preventative measure is part of the standard protocol at our phototherapy unit. To our knowledge, this phototoxicity risk has not been described in the medical literature. We illustrate this phenomenon below.

A 51-year-old woman with a 3-year history of psoriasis who failed to respond to topical corticosteroids, methotrexate, and etanercept presented for phototherapy. Physical examination demonstrated widespread plaques with marked erythema, induration, and scale covering approximately 25% of her body surface area. By day 20, she was receiving a maximally tolerated dosimetry at 600-mJ NB-UVB, but remained unsatisfied with her partial therapeutic response. Acitretin, 25 mg daily, was added.
Nine days later, the patient reported a burning sensation on her leg. Examination demonstrated marked erythema inside the plaques on her right lower extremity; the surrounding uninvolved skin was without erythema or symptoms (Fig 1). Her dosimetry was decreased by 50% to 300-mJ NB-UVB. She reported no further burn. By day 40, her psoriasis had essentially cleared. Eventually dosimetry was gradually increased, even beyond original burn thresholds to 690 mJ to her entire body and additional 660 mJ with the face covered. She continued outpatient retinoid plus UVB (ReUVB) without adverse effects and remained clear of psoriasis plaques.

We introduce the term delayed retinoid burn to designate the phenomenon occurring when phototherapy patients experience phototoxicity after addition of an oral retinoid to a maximized dosimetry to increase combination therapy efficacy rather than transitioning to a systemic immunosuppressant.

The extent of stratum corneum protection is proportional to its thickness. With delay of 1 to 2 weeks, retinoid-induced thinning in the stratum corneum makes psoriatic skin more sensitive to burning via enhanced UVB penetration. Biopsy analysis of 33 transplant patients receiving acitretin for 3 months revealed a significant reduction in stratum corneum thickness of 44%. Another study of 17 psoriasis patients treated with acitretin described a significant decrease in epidermal thickness and basal layer after 4 months. Risk of burn increases with decreasing epidermal and dermal thickness. This effect is more pronounced where the stratum corneum and epidermis have been excessively thickened by psoriatic processes, often leading to the unusual pattern of “lesional burning” while the surrounding uninvolved skin remains less affected. This phenomenon is characteristic of delayed retinoid burn, but variations in morphology are possible.

To prevent a delayed retinoid burn, the authors suggest reducing a patient’s radiation dose by at least 50% with the addition of oral retinoid. For example, a patient currently receiving 240-mJ NB-UVB who begins retinoid combination therapy should be decreased to 120-mJ NB-UVB. Subsequent dosimetry may be increased as tolerated, back to the patient’s baseline and possibly beyond, provided that no phototoxicity occurs. By following the above precautions, delayed retinoid burn is likely to be prevented in most patients.

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Blaschkoid morphea arising in a middle-aged man

To the Editor: Morphea, or localized scleroderma, is an idiopathic inflammatory condition characterized by excessive collagen deposition resulting in indurated plaques. Subtypes of morphea include plaque, linear, generalized, pansclerotic, and subcutaneous variants. Linear morphea may follow the lines of Blaschko, a concept widely disputed since the early...