Correspondence


Reply

To the Editor:

I am especially pleased to recognize the interest of Dr. Baer and his associates. Dr. Sergent referred this patient and obtained the open lung biopsy, while Dr. Glick was responsible for the electron microscopic evaluation of the patient in my report. Due to editorial considerations in the JOURNAL when my paper was processed, these contributing individuals were not acknowledged.

The detailed pathologic interpretation offered by Dr. Baer and associates provides an alternative explanation for the mechanism of the pulmonary insult in our patient. This patient's chronic obstructive pulmonary disease and emphysema may have been related both to immune complexes, as suggested by these authors, and to local elastase release by neutrophils undergoing leukocytoclastic vasculitis, as I have suggested. Further characterization awaits future clinical and pathologic studies.

I appreciate the interest and comments by Dr. Green and his colleagues regarding gastrointestinal manifestations of urticarial vasculitis. Abdominal symptoms have previously been attributed to edema of the small bowel, which has been confirmed by at least one small bowel x-ray series.

Dr. Green and his co-workers suggest that the development of diverticula is one additional cause of abdominal symptoms in these patients. I agree that a small bowel x-ray series should be performed in any patient with urticarial vasculitis manifesting gastrointestinal symptoms. As I emphasized in my discussion, one should employ an aggressive diagnostic and therapeutic approach to any patient with urticarial vasculitis.

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REFERENCES


Bullous lichen planus after intravenous pyelography

To the Editor:

We have read with great interest the article by Kerdell, Fraker, and Haynes (J AM ACAD DERMATOL 10:25-29, 1984) in which are described two cases of vasculitis related to the use of radiographic contrast media.

We hereby report the appearance of bullous lichen planus following intravenous pyelography.

Case report. A 63-year-old white man known to suffer from urolithiasis was referred to the dermatology department of the Beilinson Medical Center because of a papulovesicular eruption that had appeared a few hours after intravenous pyelography, performed with a radiocontrast media containing iodine (Urographin).* The eruption first appeared on the legs and spread within a few days to occupy the thighs, dorsal aspects of the hands, and extensor aspects of the forearms. The eruption consisted of polygonal, slightly scaling, red-vio-

Judith LI. Sack, M.D.

* Sodium methylglucamine salts of diatrizoate.
A biopsy specimen obtained from a vesicle showed a subepidermal blister containing lymphocytes and a few eosinophils. In the dermis a sparse perivascular infiltrate composed of lymphocytes and histiocytes was present. Another biopsy obtained from a papule showed findings consistent with lichen planus, including hyperkeratosis, thickening of the granular cell layer, irregular acanthosis, and a dense bandlike lymphohistiocytic infiltrate in the superficial dermis.

In view of the clinical and histologic findings in this patient, the eruption was diagnosed as bullous lichen planus. A macrophage migration inhibition factor (MIF) test performed toward a radiocontrast media containing iodine, according to a modification of the technique described by Rajapakse and Glynn,1,2 was positive (migration index, 0.63). The patient was treated with topical steroid ointments. Slow fading of the eruption was observed during the next few months.

Comment. An eruption consistent clinically and histologically with bullous lichen planus was observed in a patient a few hours following intravenous pyelography. In view of the temporal relationship observed, it is suggested that the radiocontrast media administered during the intravenous pyelography was the etiologic factor that was responsible for this dermatologic disorder.

Lichen planus and lichenoid eruptions may appear after intake of certain drugs, including iodides.3 Radiocontrast media containing iodine have been reported mainly to induce minor cutaneous reactions, as well as cutaneous manifestations of anaphylaxis (urticaria, angioedema)4 and allergic necrotizing vasculitis, as reported in the article by Kerdel, Fraker, and Haynes. In this case.

Therefore, in our patient there is in vitro evidence for a hypersensitivity reaction toward the radiocontrast media used. It is possible that such hypersensitivity reaction plays a role in the underlying mechanism responsible for the development of bullous lichen planus in this case.

**Correspondence**

**REFERENCES**


**Dermatitis herpetiformis responsive to systemic corticosteroids**

To the Editor:

The role of corticosteroids in the management of dermatitis herpetiformis is unclear. Some authors question their efficacy but there are few published studies that address this issue.

This is a report of a patient with dermatitis herpetiformis who experienced a temporary remission during treatment with prednisone.

Case report. A 50-year-old white man was referred by his family physician for a pruritic, erythematous eruption that began on his neck 4 days before and had rapidly spread to involve most of his skin. Previous medical history revealed that the patient had an in situ cell tumor of the pancreas removed in 1967 and several months before the onset of his eruption had a carcinoid tumor of the pancreas resected. The patient also had a history of peptic ulcer disease. During his last hospitalization he had developed thrombophlebitis complicated by a pulmonary embolus. Current medications included warfarin sodium and meperidine hydrochloride.

The patient was admitted to the inpatient dermatology unit of the Medical University Hospital. Crusted plaques and papules were present on the face. Excoriated edematous and erythematous plaques were noted on the forearms, in the perineal area, and in the popliteal fossae. Annular erythematous plaques involved the back and the buttocks. The left calf was tender, accompanied by 2+ pitting edema of the left leg.

The prothrombin time and partial thromboplastin time were in the therapeutic range for a patient on warfarin sodium. A urinalysis, serum amylase, sedimentation rate, complete blood count with differential white cell count, chemistry pro-