Tender Nodules on the Legs of a Cardiac Transplant Recipient

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REPORT OF A CASE

A 40-year-old woman presented with a 2-week history of lower extremity pain, diffuse arthritis, and nausea and vomiting, and a 1-week history of tender, warm nodules on her lower extremities. She had undergone orthotopic cardiac transplantation 6 months earlier and had experienced multiple episodes of rejection, which required immunosuppressive therapy. Physical examination revealed approximately 5-10 mm papulonecrotic lesions, warm, tender nodules on her lower extremities.

Figure 1.

Figure 2.

Figure 3.

Figure 4.

Figure 5.

Figure 6.

Figure 7.

Figure 8.

Multiple Light-Yellow Papules

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REPORT OF A CASE

An 81-year-old woman presented with a 2-year history of nodule, when papules continued on the neck and extremities. Two months before her initial visit, she underwent a total mastectomy for prostatic ductal lobular carcinoma and had been treated with chemotherapy, bleomycin, and cisplatin, followed by whole-lung irradiation. She had been treated with a combination of prednisone and azathioprine, which had been tapered and discontinued. She was initially evaluated for mastectomy-related complications, and physical examination revealed approximately 5-10 mm papulonecrotic lesions on the neck and the extremities.

Figure 1.

Figure 2.

Figure 3.

Symmetrical Black Plaques on the Toes

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REPORT OF A CASE

A 55-year-old African-American woman presented with a 4-year history of a progressively thickening, black mark on her toes and a 3-year history of cataracts. Five months before her initial visit, she underwent a total mastectomy for prostatic ductal lobular carcinoma and had been treated with chemotherapy, bleomycin, and cisplatin, followed by whole-lung irradiation. She had been treated with a combination of prednisone and azathioprine, which had been tapered and discontinued. She was initially evaluated for mastectomy-related complications, and physical examination revealed approximately 5-10 mm papulonecrotic lesions on the neck and the extremities.

Figure 4.

Figure 5.

Figure 6.

Figure 7.

Figure 8.

Diffuse and Progressive Papules and Nodules

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REPORT OF A CASE

A previously healthy 67-year-old white man presented with a 2-week history of a diffuse, asymptomatic cutaneous eruption that began on his trunk and progressed to involve his extremities. He primary care physician initially treated him with topical corticosteroids for presumed dermatitis, with continued worsening of the diffuse papulonecrotic plaques and a 10-lb weight loss over a 3-month period. Physical examination revealed diffuse swollen erythematous and violaceous smooth papulonecrotic plaques and nodules (Figure 1). A biopsy specimen was obtained from a lesion on the right scalp (Figure 2 and Figure 3). What is your diagnosis?
Tender Nodules on the Legs of a Cardiac Transplant Recipient

**Diagnosis:** Trench mouth infection.

**MICROBICICAL FINDINGS AND CLINICAL COURSE:**

The biopsy specimen from the left thigh demonstrated an ulcerative granuloma, with an abundant papillary dermal infiltrate. There was a moderate interstitial dermal lymphocytic infiltrate, with the greatest intensity in the upper dermis. Occasional large lymphocytes within the dermis were seen to contain abundant intracellular bacteria that were consistent with BCG (Figure 1). The bacteria were gram negative, non-acid-fast, non-motile, and surrounded by a capsule, without associated inflammation.

During the hospital course, the patient underwent a mycologic biopsy for routine evaluation of granulomas. The microbiologic analysis also demonstrated mycobacteria. The patient was treated initially with clarithromycin and pyrimethamine, and the lesion had shrunk 2 days after admission. After 2 weeks, the patient had a healing ulcer with occasional granulomas. Over a 3-week period, the skin nodules became eczematous and crusted, their loci scattered, and disappeared.

**DISCUSSION:**

Demographic manifestations of tuberculosis were first described in 1969 by Pudlo and Wackers, who demonstrated the presence of the disease in the skin of patients with tuberculosis. Their vesicles, macroscopic, papular, maculopapular, and hemorrhagic-vesicular, biotyped by dermatophages. However, since these early reports, there have been few detailed descriptions of skin manifestations of this infection. The rarity of cases in the literature may be attributable to its ease recognition, the lack of clinical suspicion by physicians, and the infrequency of skin lesions.

Recent investigations concerning cutaneous manifestations of tuberculosis have highlighted the variability of its presentation as a possible rationale for under-diagnosis. These presentations may be maculopapular, nodular, papulopapular, lichenoid, purpuric, or erythematous-violaceous. These varied dermatologic manifestations of tuberculosis can possibly be attributed to the heterogeneous systemic immune responses to the organism.

Trench mouth is a common cause of ulcers in the oral cavity, particularly the tongue. This presentation often progresses to a more severe condition, such as necrotizing fasciitis, which is a life-threatening complication. Common causes of immunocompromise pertaining to this infection are antibiotic therapy, steroid use, and immunosuppressive therapy after organ transplantation. In addition, the infection can spread from the oral cavity to the skin, with skin lesions similar to those at the oral site.

**Multiple Light-Yellow Poppies**

**Diagnosis:** Pseudomonas aeruginosa (PAB)-like papillary dermal abscess (PDA).

**MICROBICICAL FINDINGS:**

Histologically, eczema-oid lesions showed focal and diffuse edema with papillary dermal thickening. Eosinophils, fibroblasts, and fibrous tissue were present in the dermis. There were multiple foci of superficial dermal/epidermal spongiosis. Over a month period, the skin nodules became eczematous and crusty, their loci scattered, and disappeared.

**DISCUSSION:**

Over a month period, the skin nodules became eczematous and crusty, their loci scattered, and disappeared.

Symmetrical Black Plaques on the Toes

**Diagnosis:** Multisynovial autoimmune arthritis associated with carotid ulcer.

**MICROBICICAL FINDINGS:**

Histologically, eczema-oid lesions showed hyperkeratosis, papillomatosis, and perivascular and periadnexal dermal infiltration with a mixture of inflammatory cells. These lesions were associated with carotid ulcer.

**DISCUSSION:**

Acneiform skin is a common, symmetrical, papulonodular eruption, often found on the face, arms, and legs. This condition is characterized by the presence of papules, nodules, and cysts, which can progress to nodulocystic disease. The acneiform skin lesions can be associated with carotid ulcer.

Diffuse and Progressive Poppules and Nodules

**Diagnosis:** Granulomatous leukaemia seen in the presents skin (eczema-like lesions).

**MICROBICICAL FINDINGS:**

The patient began induction chemotherapy for bone marrow transplantation. He developed marked gingival hypertrophy, and failure of multiple organ systems during chemotherapy. He died 2 weeks after presentation.

**DISCUSSION:**

Lesional cutis in ulceration of the skin with leukaemia.

Acute myelogenous leukemia (AML) is a disease of malignancy involving the hematopoietic stem cell. In acute myeloid leukemia (AML), there is an abnormal proliferation of myeloblasts in the bone marrow, which can give rise to myelodysplastic syndrome (MDS) and acute myelogenous leukemia, class M6.

**REFERENCES:**


**Treatment options for AML include consolidation chemotherapy, consolidation, and stem cell transplantation.** This approach, however, is in poor. Most patients die within months of diagnosis.**