entity [1-3]. In addition to the prominent lesions on the right thigh, [3, 4, 7]. lichen striatus, lupus erythematosus, vitiligo and psoriasis mal nevus, sebaceous nevus, lichen nitidus, lichen planus, skin conditions follow the lines of Blaschko. They include dermatoses are known to exist. Many nevoid and acquired clinical features, absence of itching, histopathological findings and response to ultraviolet radiation may help in distinguishing it [1, 3, 5]. The naevoid psoriasis might co-exist with [6] or develop as an isomorphic phenomenon over a pre-existing ILVEN [4]. The lines of Blaschko are different from Langer’s and exist with [6] or develop as an isomorphic phenomenon over a pre-existing ILVEN [4]. The skin lesions of naevoid psoriasis clinically and histologically resemble adult psoriasis, but their presence at birth or in early childhood and their distribution often helps the diagnosis. The lines can mimic inflammatory linear verrucous epidermal naevus, but the classical clinical features, absence of itching, histopathological findings and response to ultraviolet radiation may help in distinguishing it [1, 3, 5]. The naevoid psoriasis might co-exist with [6] or develop as an isomorphic phenomenon over a pre-existing ILVEN [4]. The skin lesions of naevoid psoriasis clinically and histologically resemble adult psoriasis, but their presence at birth or in early childhood and their distribution often helps the diagnosis. The lines can mimic inflammatory linear verrucous epidermal naevus, but the classical clinical features, absence of itching, histopathological findings and response to ultraviolet radiation may help in distinguishing it [1, 3, 5]. The naevoid psoriasis might co-exist with [6] or develop as an isomorphic phenomenon over a pre-existing ILVEN [4].

Discussion
The existence of naevoid psoriasis as a distinct entity has been a topic of debate. There have been reports of congenital psoriasis starting at birth [1-3]. Some of these were reported to have subsequently developed classical psoriatic plaques later on in life [2, 3]. Some believe that the lesions may in fact represent the in...migrating lesions and scaling at the trailing edge [2].
The occurrence of psoriasis in a naevoid form probably reflects mosaicism for a gene responsible for psoriasis [1, 2, 4-6]. The skin lesions of naevoid psoriasis clinically and histologically resemble adult psoriasis, but their presence at birth or in early childhood and their distribution often helps the diagnosis. The lines can mimic inflammatory linear verrucous epidermal naevus, but the classical clinical features, absence of itching, histopathological findings and response to ultraviolet radiation may help in distinguishing it [1, 3, 5]. The naevoid psoriasis might co-exist with [6] or develop as an isomorphic phenomenon over a pre-existing ILVEN [4]. The skin lesions of naevoid psoriasis clinically and histologically resemble adult psoriasis, but their presence at birth or in early childhood and their distribution often helps the diagnosis. The lines can mimic inflammatory linear verrucous epidermal naevus, but the classical clinical features, absence of itching, histopathological findings and response to ultraviolet radiation may help in distinguishing it [1, 3, 5]. The naevoid psoriasis might co-exist with [6] or develop as an isomorphic phenomenon over a pre-existing ILVEN [4].

Erythema gyratum repens as the initial manifestation of lung cancer
Erythema gyratum repens is a rare reactive erythema and most cases are associated with internal malignancies [1]. It presents as a polycyclic figure erythema, with rapidly migrating lesions and scaling at the trailing edge [2]. We describe a 69-year-old Caucasian male, with a two-month evolution of multiple erythematous arciform lesions, giving a wood-grain appearance. The lesions migrated rapidly, leaving a thin scale at the edges (figure 1). The diagnosis of psoriasis started on the face, but soon generalized and became more exuberant on the trunk. Pruritus was intense, and the patient had previously taken oral corticosteroids with partial improvement, but rapid worsening occurred after stopping treatment. The histopathology was non-specific, showing hyperkeratosis, orthokeratosis, mild acanthosis and a scarce superficial perivascular lymphocytic infiltrate. Mild chronic obstructive pulmonary disease, related to previous smoking, and arterial hypertension were the only relevant co-morbidities. The patient denied any weight loss, dyspnea, hemoptysis, or worsening of his long-standing cough. As the clinical picture was consistent with erythema gyratum repens, investigations for occult neoplasia were started, and lung computer tomography (CT) revealed a solid nodular lesion on the upper superior right lobe, together with mediastinal enlarged lymph nodes. A bronchofibroscopy with biopsy was performed and a lung adenocarcinoma was diagnosed and staged as T4N2M0. No other endocrine, neurological or skeletal-connective tissue paraneoplastic syndromes were present. Chemotherapy with oral vinorelbine and carboplatin was started, and progressive improvement of the skin lesions was noticeable after one week. Initially there was a reduction in both erythema and scaling, but still in a wood-grain pattern. After 12 weeks the patient had almost complete improvement of the skin lesions, and the lung CT scan confirmed that chemotherapy had effec-


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Figure 1. A) Linear bands of erythematous, scaly plaques on the right thigh along the lines of Blaschko. B) Histopathology showing hyperkeratosis, parakeratosis, focal agranulosis, Munro’s microabscess, acanthosis and papillomatosis (haematoxyline and eosin; original magnification × 40).

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Paraneoplastic manifestations are common with lung malignancies, in particular clubbing, hypertrophic pulmonary osteoarthropathy and endocrine or neurological syndromes. Other cutaneous manifestations of lung cancer such as dermatomyositis, acanthosis nigricans and migratory venous trombophlebitis (Trousseau’s syndrome) are very uncommon [6]. As the condition is a reactive dermatosis, treatment of the underlying disease usually results in rapid resolution [1]. Surgical treatment was not possible in our patient due to the advanced stage, but the reduction of the tumour burden with chemotherapy resulted in a marked improvement of the cutaneous lesions. In conclusion, a complete clinical history and examination is warranted when evaluating figure erythemas, and the possibility of an associated neoplasm must be investigated.


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Minocycline in combination with mycophenolate mofetil in oral mucous membrane pemphigoid

Mucous membrane pemphigoid (MMP) is a heterogeneous group of sub-epithelial blistering diseases having an unpredictable natural history [1]. We present two patients affected with severe predominantly oral MMP without a scarring phenotype in whom standard treatments gave limited and temporary disease control. The patients were then successfully treated with a new therapeutic approach based on the combination of mycophenolate mofetil and systemic minocycline. On September 2001, a 68-year-old woman presented with a 1-year history of painful oral ulcers. Oral examination revealed widespread ulcerations (figures 1A and C) without

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