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Lymphangitis due to Insect Sting

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Key Words
Lymphangitis · Insect sting

We describe the case of a patient with unusual skin lesions that we believe to be a form of presentation of insect stings or bites.

A 62-year-old man, with no notable medical history apart from allergic rhinitis, consulted our out-patient clinic in July 2003 with pruritic lesions that had appeared 3 days earlier during a 10-day vacation in Narbonne, South of France. The patient had noted a progressive increase in the size and number of lesions, as well as the secondary formation of erythematous linear trails from certain lesions in the direction of regional lymph nodes. Clinically, he presented 6 erythematous plaques on the trunk as well as upper and lower limbs, certain of which had a purpuric centre, with lymphangitis arising from 2 of the lesions on the right anterior chest wall and lower left abdomen towards the right axillary-supraclavicular and left inguinal lymph nodes, respectively (fig. 1). The lesions were tender but there were no systemic symptoms, fever or lymphadenopathy.

The patient history revealed that he had gardened on several occasions during his vacation amongst bay trees and brambles wearing only a bathing costume. There was no history of sea bathing.

We concluded that insect stings or bites had caused secondary lymphangitis, the latter being of either toxic, allergic and/or infectious nature. There was no evidence for leishmaniasis or rickettsioses, and *Borrelia* serology was negative. Jellyfish sting was excluded since the patient did not swim in the sea. Phytophotodermatosis was also considered but seemed unlikely in view of the distinctive multiple lymphangitis.

The patient refused systemic corticosteroids and was initially treated by topical betamethasone (Diprolène®) and oral hydroxyzine (Atarax®). He consulted again 4 days later as the size and number of lesions had increased again (10 in total). The lesions had become more painful but there were still no systemic symptoms or lymphadenopathy. He was given a treatment consisting of oral levofloxacin (Tavanic®) 500 mg daily for 1 week and topical fusidic acid which led to complete healing of the lesions.

We believe this to be a novel manifestation of a particular insect sting or bite since this appears to be a pattern that has also been observed recently by others.[1] Three patients are described with a sudden eruption on the trunk and upper limbs ranging from 1 to 10 lesions with secondary lymphangitis but no lymphadenopathy or systemic symptoms, which healed spontaneously without treatment. Interestingly, these cases were seen at the university hospital in Montpellier, which is only 100 km away from Narbonne where our patient resided.

The causative insect and the potential infectious agent transmitted remain to be identified as does the nature of the lymphangitis, which could be of toxic, allergic and/or infectious origin. Indeed, linear supralymphatic eruption resulting from minor injury is thought to be of infectious and allergic origin, the presence of bacteria such as *Staphylococcus aureus* being necessary to trigger an auto-immune reaction by potentially unmasking a novel membrane antigen on target skin cells [1]. The fact that the lesions regressed rapidly in our patient after antibiotic treatment pleads in favour of an infectious agent but this point still needs to be confirmed.

[1] Marque M, Girard C, Guillot B, Bessis D: Dermite érythémateuse linéaire supra-lymphatique réactionnelle: une nouvelle entité clinico-histologique (abstract). Journées Dermatologiques de Paris, 2006.

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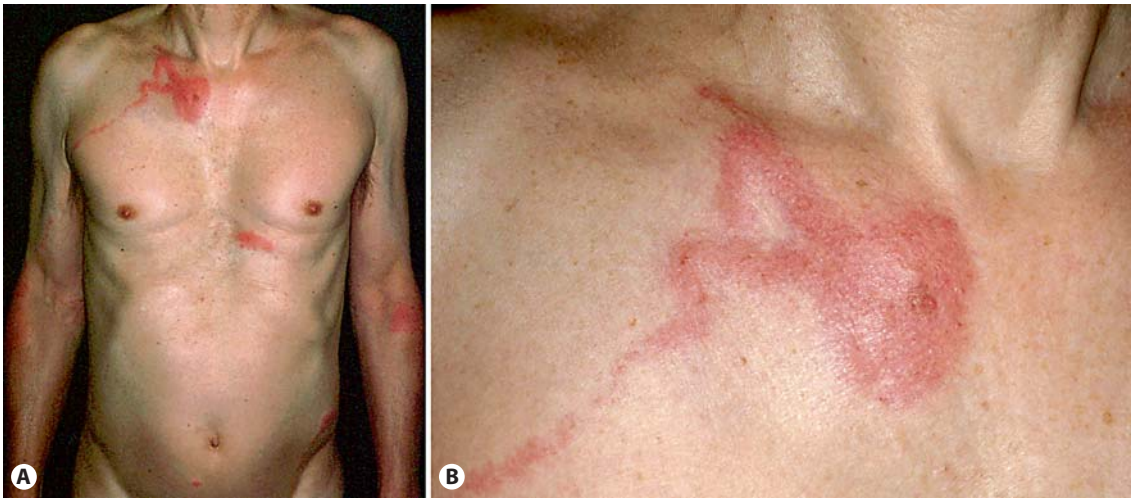

Fig. 1. A Multiple erythematous plaques on the trunk, upper and lower limbs with secondary lymphangitis. **B** Detail of the lesion on the right anterior chest wall: erythematous plaque with a purpuric centre and secondary lymphangitis in the direction of the supraclavicular and axillary lymph nodes.

Although unique lymphangitis arising secondary to insect bites is well known, especially on the lower limb, accompanied by fever, redness of the lower extremity, and inguinal lymphadenopathy, multiple lesions on the trunk are less frequent [2]. Lymphangitis secondary to spider bites has also been described but usually involves a single, necrotic lesion and the markings of the chelicerae (fangs) are often visible [3].

In summary, it is not unlikely that this is a novel manifestation of insect stings or bites presenting as multiple plaques on the trunk and limbs with secondary lymphangitis.

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Neutrophilic Eccrine Hidradenitis with Sclerodermoid Change Heralding the Relapse of Acute Myelogenous Leukemia: Is This a Paraneoplastic Phenomenon?

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Neutrophilic eccrine hidradenitis · Acute myelogenous leukemia · Scleroderma · Paraneoplastic phenomenon

Neutrophilic eccrine hidradenitis (NEH) was originally described as a distinctive dermatosis occurring in patients undergoing chemotherapy, especially associated with the use of cytarabine in the treatment of acute myelogenous leukemia (AML) [1]. Occasionally, NEH is a clinical marker for the onset or relapse of hematologic malignancies [2–4]. NEH is characterized by a neutrophilic infiltrate around the eccrine glands and coils and is associated with necrosis, however, no sclerodermoid changes have been reported. Here, we report sclerodermoid changes observed in a case of NEH heralding an AML relapse, suggesting that sclerodermoid changes might develop as a paraneoplastic syndrome.