exhibited a positive (++) allergic reaction to tamoxifen diluted in vaseline (fig. 2). The controls were negative. The skin biopsy specimen of the positive test showed a superficial perivascular chronic dermatitis, similar to the histopathology picture of the original lesions.

Adverse reactions of systemic drugs are frequently described. Tamoxifen is a hormonal antagonist broadly used in the prevention of breast cancer recurrence. There are different cutaneous reactions reported, most of the time without confirmation. The adverse reactions usually described are thromboembolism and maculo-papular eruption.\(^1,2\)

The case described in this letter illustrates a pseudolymphoma as an adverse reaction of tamoxifen, confirmed by the positive patch test. The patient continues using tamoxifen, and the cutaneous lesions persist; however, we prescribed symptomatic medications as anti-histamine and topical corticoids with good results.

FR Gatti,† MC Pires‡*
†Department of Dermatology, Hospital do Servidor Público Estadual, ‡Department of Dermatology, Complexo Hospitalar Padre Bento, Guarulhos, *Corresponding author, R. Caraíbas, 533 apto 101 – São Paulo-SP, Brazil 05020-000, tel./fax +55 11 5088 8293; E-mail: mapires@webcable.com.br

References

DOI: 10.1111/j.1468-3083.2007.02474.x

Embolia cutis medicamentosa following thiocolchicoside injection

Editor

Nicolau syndrome (NS), or embolia cutis medicamentosa, consists of immediate excruciating pain, early pallor and erythema-oedema at the site of intramuscular injection of drugs, followed by cutaneous, subcutaneous and even muscular aseptic necrosis in a livedoid pattern.\(^1\)

A 66-year-old Caucasian woman, treated with thiocolchicoside (4 mg/2 mL intramuscularly) for lower back pain, complained, immediately after drug administration, of extreme pain and tenderness radiating to the posterior part of the left leg and to the calf, with blanching at the injection site and localized livedoid patch. Twenty-four hours later, a phlyctena appeared, followed by extensive cutaneous necrosis.

One week later, due to persistence of symptoms, the patient presented for consultation. Dermatological examination showed a painful black scar (3.7 × 2.4 cm), demarcated by an erythematous-violaceous border, in the upper outer quadrant of the left buttock (fig. 1).

The patient was otherwise healthy; routine laboratory examinations, including creatinine kinase, were normal. Bacteriological culture of swabs showed only resident flora.

We diagnosed NS and prescribed oral cefotaxime (400 mg/day for 5 days) and nimesulide β-cyclodextrin (100 mg, symptomatically); in addition, the patient was referred to Plastic Surgery Unit for possible debridement intervention. The lesion healed after 12 weeks, leaving an atrophic scar.

FR Gatti,† MC Pires‡*
†Department of Dermatology, Hospital do Servidor Público Estadual, ‡Department of Dermatology, Complexo Hospitalar Padre Bento, Guarulhos, *Corresponding author, R. Caraíbas, 533 apto 101 – São Paulo-SP, Brazil 05020-000, tel./fax +55 11 5088 8293; E-mail: mapires@webcable.com.br

References

DOI: 10.1111/j.1468-3083.2007.02474.x
NS is a rare condition, first described by Freudenthal and Nicolau, which has been successively associated with injection of several drugs. Typically, NS presents with pallor, oozing to local reflex vasospasm, and pain, rapidly followed by erythema, livedoid/haemorrhagic patch, blistering and, finally, variable features of necrosis.

Evolution is unpredictable: myositis, abscess, nerve palsies, muscle atrophy possibly occur. A rare, but reported, life-threatening complication is necrotizing fascitis.¹

Most recommend immediate treatment with vasoactive substances such as heparin and systemic corticosteroids. Local measures, pain control, antibiotic prophylaxis and conservative surgical interventions are also helpful.

Medications associated with NS include bismuth, pyrazolone derivatives (phenylbutazone), diclofenac, ibuprofen, vitamin B complex, sulphydryl, tetracycline, streptomycin, sulphonamide, lidocaine, phenobarbital, chlorpromazine, dexamethasone, triamcinolone, vitamin K, diphenhydramine, interferon alfa, gentamicin, ketoprofen. Cases of NS following intramuscular anti-flu and triple DPT vaccinations have also been reported.¹³

The pathogenesis of NS is unclear. It was initially ascribed to immunologic/allergic mechanisms, injection technique, speed of injection, pH or other chemical–physical features of the administered drug, but experimental studies disproved these hypotheses.

Nowadays, intra-arterial or periarterial injection of the offending medication seems to be the most plausible causative event, with subsequent vasospasm, then thrombosis and necrosis in the area supplied by the vessel providing the characteristic clinical picture.¹³

Furthermore, Cockshott et al. highlighted the difficulties in performing intramuscular injection, with only 5% of females and 15% of males receiving the drug properly.⁴

Thiocolchicoside is a semisynthetic derivative of colchicoside, with selective affinity for gamma-aminobutyric acid and glycnergic receptors. It is used as muscle relaxant agent in the symptomatic treatment of spasms and contractures in muscular, rheumatic, traumatic and neurological disorders, with rarely reported adverse events. The chemical–physical characteristics of thiocolchicoside, as well as its pharmacological effect, which is completely different from those of the drugs previously related to NS, allow to exclude both the embolic occlusion of small skin arteries and the acute vasospasm theories. Our case rather seems to support the unifying hypothesis of an unintentional paravasal injection, with direct trauma and/or inflammation of vessel structures, destruction of arterial wall and subsequent skin necrosis; this phenomenon has been also reported in experimental animal models.⁶

To our knowledge, there are no cases of NS following intramuscular injection of thiocolchicoside reported in literature or in the WHO Adverse Drug Reactions database.

C Guarneri,*† G Polimeni,‡ F Guarneri,§ S Cuzzocrea¶
†Department of Social Territorial Medicine, Section of Dermatology, University of Messina (Italy), ‡Department of Clinical and Experimental Medicine and Pharmacology, Section of Pharmacology, University of Messina (Italy) & IRCSS Centro Neurolesi ‘Bonino-Pulejo’, Messina (Italy), ¶Department of Social Territorial Medicine, Section of Dermatology, University of Messina (Italy), ©Department of Clinical and Experimental Medicine and Pharmacology, Section of Pharmacology, University of Messina (Italy), *Corresponding author, Institute of Dermatology – A.O.U. ‘G. Martino’, Via Consolare Valeria, Gazzè –98125 Messina (Italy), tel. +39 0902212891; fax +39 0902927691; E-mail: claudioguarneri@tiscali.it

References

DOI: 10.1111/j.1468-3083.2007.02527.x

Urticarial vasculitis with haemorrhagic vesicles successfully treated with reserpin

Editor
We herein describe a case of urticarial vasculitis successfully treated with reserpin. A 49-year-old Japanese man had suffered from swelling of the lip and pruritic eruption on the trunk and extremities with high fever for a couple of days. The individual lesions lasted for 48 h. He had taken amlodipine and aspirin for hypertension with atrial fibrillation. On physical examination, his body temperature