of the lesion exudate was negative. Furthermore, serology for Coxsackie A, Coxsackie B1, B2, B3, B5, B5 viruses, Cytomegalovirus and Mycoplasma was negative, as well as the polymerase chain reaction for the detection of herpes simplex virus and varicella-zoster virus, which had been performed on material taken from the skin lesions. The plasma immunoglobulin levels, the C3 and C4 complement component levels, the CD4 lymphocyte count and the CD4/CD8 ratio were all normal; antinuclear antibodies were absent. Blood cultures were positive for Pseudomonas Aeruginosa and the antibiogram confirmed the efficacy of ceftriaxone. After the institution of antibiotic therapy, the fever resolved rapidly and the skin lesions healed with scarring after 45 days (figure 1C-D).

Pseudomonas Aeruginosa septicemia causes typical skin lesions known as ecthyma gangrenosum. Multiple lesions occur in immunocompromised patients [1] and in such cases the mortality rate is very high with death occurring in up to 90% of patients [2]. In our case, multiple lesions occurred even though the patient was not immunocompromised (as established by laboratory examination). Moreover, despite the usually adverse prognosis in Pseudomonas Aeruginosa septicemia, our patient healed. The prompt clinical diagnosis and immediate starting of targeted antibiotic therapy, combined with the absence of an underlying immunodeficiency, determined the favourable outcome.

Moyamoya disease is a cerebrovascular disorder whose cause is unknown. The disease is characterised by intracranial stenosis of the carotid arteries and compensatory collateral vascular network, which is angiographically characterised by a “puff of smoke” appearance (moyamoya is the Japanese word for “cloud of smoke”). In the medical literature several cases of moyamoya disease in association with recurrent tonsillitis, tubercular or leptospiral meningitis have been described, leading some authors to suggest that bacterial infections of the neck, through the inflammation of the sympathetic innervation of the internal carotid arteries, could induce the vascular manifestations which characterize this disease [3]. Furthermore, ecthyma gangrenosum has been reported in a patient affected by harlequin fetus [4] and moyamoya disease has been associated with livedo reticularis [5] but the cause for such associations remained unexplained. The association between ecthyma gangrenosum and moyamoya disease appears to be accidental in our case as well, because moyamoya disease is not characterized by any kind of deficit of the immune system.

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**Could a photobiological test be a suitable method to assess the anti-oxidant effect of a nutritional supplement (Glisodin®)?**

The objectives of this study were to determine the ability of a photobiological test to assess the anti-oxidant effect of a nutritional supplement. The photoprotective effect of Glisodin® was studied by Minimal Erythematous Dose (MED) before and after treatment and its efficacy as a treatment of actinic erythema was assessed by biometrological measurements in 49 healthy subjects (10 phototype II, 19/III, 20/IV).

Glisodin® is known to be a promoter of the production of natural antioxidants [1, 2]. In this study, the values of MED as well as a global erythema score of all the irradiated sites of each subject were assessed with the Said-Maurin Test before and after treatment. An actinic erythema (3 x MED) was induced by a solar simulator (Dermolum UM®, Müller, Elektronik-Optik, Germany) on the subjects’ volar forearm. Glisodin® or a placebo were then taken orally on the following day and daily over 4 weeks. In each phototype group, half of the subjects received the supplement (3 × MED) was induced by a solar simulator (Dermolum UM®, Müller, Elektronik-Optik, Germany) on the sub-

**Figure 1.** Necrotic ulcers with erythematous border on the abdominal region and on the left thigh (A, B); the same lesions after antibiotic therapy (C, D: scarring after 45 days)
the forearm) decreased but no differences were observed between both groups. Redness (a%) decreased rapidly in the Glisodin® group (– 37% over one week with active versus – 28.6% with placebo for phototype II, – 28.6% versus – 28.8 % for phototype III and – 32.5% versus – 27.6% for phototype IV). The number of capillaries increased with time (+ 24.6% after one week with active versus –8.4% with placebo for phototype II, + 44.4% versus + 17.5% for phototype III and + 6.5 % versus + 3.0% for phototype IV). This progression could be explained by the quicker return to basal values with GliSODin®. Although there was no significant difference between the treated group and the placebo group, this study suggests that the efficacy of the treatment in solar protection and on actinic erythema seems better on the lowest phototypes. It would be interesting to complete the investigation with a more homogeneous and numerous population (phototype II and III), with measurements taken daily during the first week at the beginning of the study and a pre-treatment (2 or 3 weeks).


Monoclonal gammopathy of undetermined significance diagnosed by cutaneous manifestations of AL amyloidosis

AL amyloidosis is the only form of amyloidosis that is secondary to clonal plasma cell dyscrasias [1]. Clinically evident mucocutaneous involvement in AL amyloidosis is an early symptom for a diagnosis of an underlying plasma cell dyscrasia [2, 3].

We present a case of AL amyloidosis associated with monoclonal gammopathy of undetermined significance (MGUS).

Case

A 56-year-old man applied to our clinic with purple lesions on the eyelids and enlargement of his tongue in the last 6 months. The physical examination was normal. On dermatological examination, enlargement of the tongue and echymotic lesions were observed at the periorbital region, the lateral sides of neck and supraclavicular region (figure 1A).

In laboratory examinations, chronic anemia, increased serum IgA levels, hypergammaglobulinemia in protein electrophoresis, IgA lambda monoclonal gammopathy in serum capillary immunofixation electrophoresis, and lambda light chains in urine capillary fixation electrophoresis were detected. The quantitative protein, calcium and creatinin levels in 24 hour urine were within normal limits. No pathology was demonstrated in the abdominopelvic ultrasonography and bone surveys. Bone marrow cytology and histopathological examination revealed myeloid and erythropoietic cells, a few megacaryocyte and plasma cells.

The histopathological examinations of the biopsies taken from the lesions on the neck, tongue, rectum mucosa, and non-lesional skin revealed metacromatic staining with cristal violet and Congo red staining of amyloid deposits (figure 1B). Immunohistochemical examinations of these biopsies demonstrated AL type amyloid staining (figure 1C). The patient was diagnosed as MGUS and he is still under observation.


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Figure 1. A) Amyloidosis lesions on neck and periorbital area. B) The Congo red staining of amyloid deposits (Congo red, x50). C) Positive staining with immune lambda antibodies on immunohistochemical examination of the lesions (x50)