patients, often with spontaneous resolution of the macular oedema. In type 2 patients, especially if they are older, it is best to treat the macula first, as extensive peripheral laser treatment may worsen macular oedema.

None of the treatments currently available is totally effective, but several clinical trials now in progress may find newer more effective treatments to prevent visual loss.

Competing interests: EK had a grant from MRC and NEI, and has acted as an expert witness.

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Lesson of the week

Zosteriform metastasis from melanoma

A V Evans, F J Child, R Russell-Jones

Cutaneous metastases from primary tumours, including malignant melanoma, can imitate herpes zoster (shingles)

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Approximately 10% of metastases from all primary neoplasms involve the skin, but for malignant melanoma the figure is 44%.[1] In some cases of melanoma this is the presenting feature, either because the primary lesion has regressed completely or because it has been unnoticed or ignored by the patient. Occasionally the melanoma has originated at an extracutaneous site such as the retina or the anal canal.

Metastases from cutaneous melanoma normally present as flesh coloured papules or nodules in the skin. Only about a third are pigmented or ulcerated. We report a case in which cutaneous metastases from a melanoma imitated herpes zoster. This presentation is known as zosteriform metastasis; it also occurs with other neoplasms.

Case report

A 73 year old white man presented with a three week history of painful, pruritic vesicles on a background of erythema on the right frontal area of the scalp (figure). The lesion had not responded to self prescribed topical antibiotics and antiseptics. The patient had grown up in South Africa and had a history of excessive exposure to the sun. He had previously developed three basal cell carcinomas and had numerous actinic keratoses. Five years earlier a malignant melanoma, Breslow thickness 1.25 mm, had been excised from his right shoulder. At that time there had been no evidence of metastatis. He had been followed up regularly and there had been no evidence of recurrence. He also had a five year history of stage Ib mycosis fungoides.

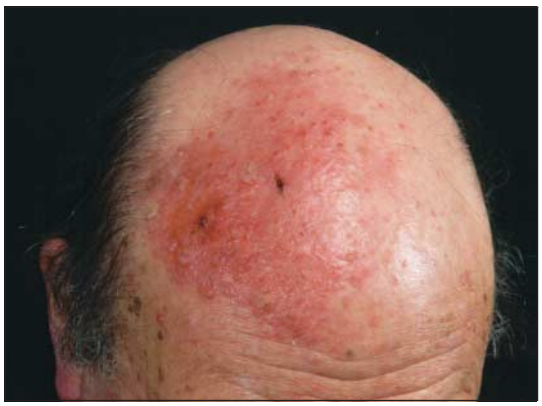
Clinical examination showed that the lesion lay within the area supplied by the ophthalmic branch of the right trigeminal nerve. A provisional diagnosis of herpes zoster (shingles) was made, and he was treated with 800 mg of oral aciclovir five times a day. There was no history of herpes zoster at the same site or elsewhere.

He was reviewed seven days after starting aciclovir. The lesions had extended slightly but otherwise remained unchanged. At that point a diagnosis of plaque stage mycosis fungoides was considered, and the scalp lesion was biopsied. Histological examination showed that the dermis was heavily infiltrated by non-pigmented malignant cells, which were epithelioid in appearance and forming nests; immunostaining showed that these cells were metastatic melanoma.

The area was too extensive to excise. After discussion with the patient the lesion was treated with electron beam radiotherapy (40 Gy in 15 fractions). The response was dramatic and within a few weeks the lesion regressed almost completely except for some residual macular erythema.

Discussion

Many different malignant tumours can metastasise to the skin but the commonest primary sources are tumours of breast, stomach, lung, and uterus. These lesions usually present as firm papules or nodules, both of which may ulcerate; occasionally they are inflammatory, sclerotic, bullous, or vesicular. Zosteriform metastasis is less well known; it may arise from adenocarcinoma of the lung,[2 3] carcinoma of the prostate,[4 5] Kaposi's sarcoma,[6 7] transitional cell carcinoma of the bladder,[8] or malignant melanoma.[9 10] Zosteriform metastases are usually painful, tender, or pruritic and consist of vesicles on a background of erythema,



Zosteriform metastasis from malignant melanoma

imitating the appearance of shingles. They are commonly confined to a single unilateral dermatome, adding to the potential for misdiagnosis. Our patient presented with zosteriform metastases which we initially misdiagnosed as herpes zoster.

It is obviously important to recognise metastatic disease. Firstly, it may indicate an occult malignancy and call for a vigorous search for the primary lesion, which may be internal; if the primary lesion is cutaneous it may have been unnoticed or ignored by the patient. Secondly, metastatic disease may represent progression of a known malignancy, requiring a change in management.

The mechanism for the zosteriform appearance of metastatic disease is not known. It has been postulated that recent herpes zoster might induce infiltration of malignant cells in a Koebner-like phenomenon.[6 11] Our patient had no history of herpes zoster or any other skin lesion in this area. Perineural lymphatic spread of malignant cells has been suggested as a mechanism[2 4 5 12]; invasion of the dorsal root ganglia with subsequent peripheral spread is another hypothesis.[3 8 12] Our case also highlights the value of histological examination in the management of skin lesions that do not respond to treatment.

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A memorable patient

The value of communication

I expect she is back in Vietnam now. I often think about her and her family.

She was a pleasant child, with limited Cantonese picked up from her many years spent in a detention camp in Hong Kong. She had had a relapse of her nephrotic syndrome and had stayed with us a while until diuresis occurred, as the camps were not suitable for someone receiving high dose corticosteroids. She also had a history of asthma, which was quiescent at the time.

We got on well, despite the language barrier. I guess one doesn't need many words during play. I explained her condition to her softly spoken mother through an interpreter. I learnt that they had been in the camp for a few years and that she loved all her children very much, that they were all she had after her husband had died in a camp fight.

It was coming up to a local festival, and the mother was keen to have her family together for the occasion. The wards were quiet, the child's corticosteroids had been reduced, and she was stable. I agreed that she could return to the camp for the holiday period.

After the holiday, I discovered that the child had had to be admitted to the intensive care unit. She had had a severe asthma attack, required ventilation, and suffered cerebral hypoxia. No one blamed me. After all, her asthma had been under control when she left. I felt incredibly guilty, though, and I didn't want to face the mother. Nevertheless, facing up to parents was part of the job, so again I called in the interpreter and tried to explain what was being done to help, explained what could have happened, and expressed my regret at the situation. The mother just cried.

The child made a surprisingly good recovery. With physiotherapy and speech therapy, she regained most of her speech and mobility. I wrote letters and made many telephone calls to camp officials, insisting that the mother be allowed daily visits to the hospital.

During those weeks of recovery, the mother didn't say much to me, despite our many meetings via an interpreter. She seemed to accept the turn of events, and I was just pleased that the child was able to walk out of the hospital independently. What did it matter if the mother didn't think much of this junior doctor's management?

On the day of discharge, the mother handed me a package wrapped in newspaper and thanked me for helping them. It turned out to be the most beautiful hand-knitted jumper I had ever seen. This treasured item serves as a reminder to me to be always truthful to my patients, and their families, and to be sure to spend time communicating with them, regardless of the disease and management outcome, because families always appreciate honesty and genuine concern.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.