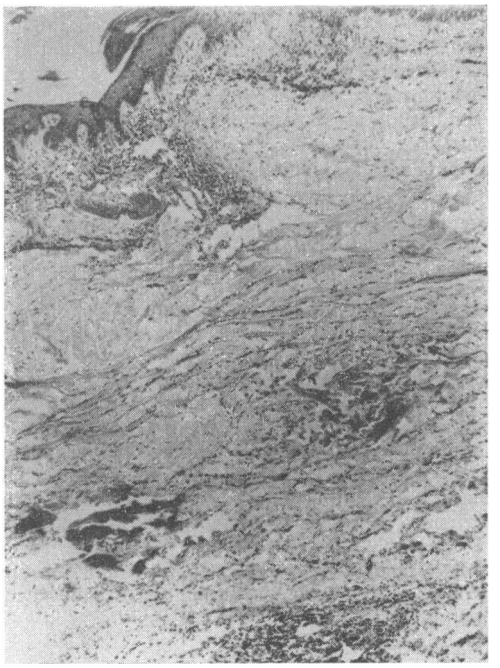

Fig 3 *Section from buttock showing deep in the dermis focal areas of calcification and perivascular lymphocytic infiltration.* × 30

thin-walled telangiectatic vessels. Deeper in the dermis is a marked perivascular lymphocytic infiltration and there are also focal areas of calcification affecting elastic fibres to a conspicuous degree (Fig 3).

Treatment: Hydroxychloroquine sulphate tablets (Plaquenil) 200 mg twice daily for three weeks (two months ago) with noticeable improvement.

Comment

The uncommon entity of lupus erythematosus profundus as a variant of cutaneous LE is well established but inflammation of the panniculus as a presenting feature of systemic LE is rare, though Winkelmann (1970) described 3 such patients and quoted 6 other reported cases. He emphasized that the lesions do not differ from those of LE profundus except that the LE syndrome is systemic.

This patient presented with panniculitis over the buttock, but I do not consider at present that we can definitely say that her disease is systemic. Although she has a positive antinuclear factor, LE cells have been demonstrated, and her ESR is raised, she has no systemic symptoms and her WBC, MSU and serum proteins are normal.

REFERENCE
Winkelmann R K (1970) *J. Amer. med. Ass.* **211**, 472

Dr E Wilson Jones: Dr Winkelmann (1970, *J. Amer. med. Ass.* **211**, 472), when drawing attention to ulcerative sclerotic plaques occurring on the buttocks in systemic lupus erythematosus, published a photomicrograph showing calcification of elastic fibres in the vicinity of a nodule. No explanation for this unusual finding was forthcoming.

Dr M Feiwel: In a review of the concept of Weber-Christian panniculitis (Macdonald & Feiwel, 1968, *Brit. J. Derm.* **80**, 355) Case 5 was that of a woman with a fifteen-year history of recurrent indurated and ulcerating subcutaneous nodules on the buttocks. A positive LE test was found on six occasions in 1960 and 1961 but has been negative since.

Cutaneous Mastocytosis: An Unusual Radiation Dermatitis

Angus Macdonald MB MRCP (for M Feiwel FRCP)
(St Mary's Hospital, Praed Street, London W2)

Woman, aged 61

Referred by Radiotherapy Department because of a rash which she had developed after receiving routine post-operative therapeutic X-irradiation for breast carcinoma.

Pre-operative clinical findings were of a Stage 2 breast cancer with retracted nipple; no glands were palpable, but an extended simple mastectomy was performed. Histopathological examination of the specimen obtained showed the lesion to be a well-differentiated primary mammary carcinoma with microscopic involvement of four out of six excised glands. Six weeks after operation she started a routine course of post-operative radiotherapy, receiving over the next three weeks 2,400 R to the chest wall and lymph node area. This was followed by the expected primary irradiation reaction, which settled rapidly and spontaneously.

Four months after completing the course of radiotherapy, and long after the primary reaction had completely settled, she developed an eruption on the chest wall which spread over the subsequent few weeks to involve the exact area exposed to radiotherapy (Fig 1). The lesions were small (<0·5 cm), erythematous and scaly, and they have remained static and symptomless.

General health was good. There was no evidence of any spread of the malignant disease; mild facial rosacea was her only other complaint.

Examination revealed that in addition to the rash as described there were a few minute red papules present on the arms and thighs, which darkened on rubbing.

Histopathology: The first biopsy, from the lesion on the chest wall, showed superficial collagen degeneration, numerous mast cells, and epidermal

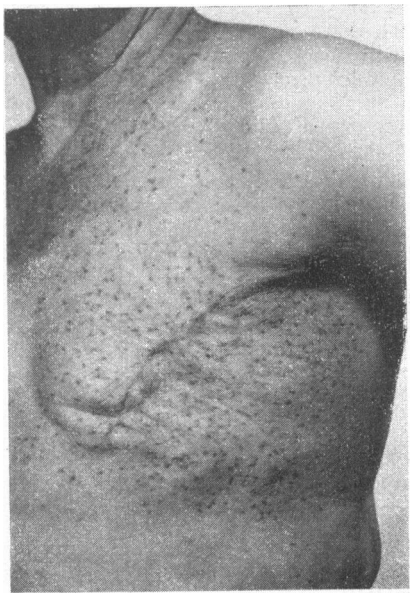

Fig 1 *Limitation of the eruption to the area of skin receiving irradiation*

spongiosis and hyperkeratosis; the findings were considered compatible with changes induced by X-rays. The second biopsy, from a small red papule on the right thigh, demonstrated the presence of mast cells, but there were no more than four round any one vessel, and the changes were not thought to be enough to support the diagnosis of mastocytosis. The third biopsy, from the chest wall, revealed, after much sectioning, an area where mast cells were present in great excess. A diagnosis of mastocytosis was confirmed by this section.

Discussion

In this patient a definite diagnosis of cutaneous mastocytosis was delayed by two factors: first, mast cells are found in excess following ionizing irradiation injury to the skin and, secondly, we were quite unfamiliar with the development of mastocytosis in this Koebner-like manner.

It is not reported in any major textbook or review as a feature of the disease though J S Comaish (1970, personal communication) has drawn our attention to a case of his in which a patient with known mastocytosis developed numerous lesions typical of this condition in the site of a vigorous hypersensitivity reaction to Elastoplast.

It would appear that individuals with cutaneous mastocytosis may rarely develop mast cell 'lesions' in circumstances which in normal individuals produce only self-limiting inflammatory changes.

Dr H J Wallace: She also has a few longstanding brownish lesions on the inner aspect of the left arm which urticate on rubbing. If the diagnosis of urticaria pigmentosa is confirmed by biopsy, I suggest that this recent eruption is a mastocytosis provoked by irradiation.

Dr K V Sanderson: I should like to support the diagnosis of mastocytosis of the macular type.

Dr J S Comaish: I also support a diagnosis of mastocytosis and suggest that one of the lesions present on the right arm should be biopsied to exclude any changes seen as being due to irradiation.

Dr D D Munro: About eight years ago I showed, at the clinical meeting of the British Association of Dermatology in London, a patient who had developed a widespread lymphangioma over the right side of the chest following radical mastectomy and radiation. Many of the dermatologists present felt that the surgery and irradiation had produced clinical manifestations of a lymphangioma which had been present previously.

I agree that this patient's signs are suggestive of urticaria pigmentosa, and I wonder if radiation precipitated the clinical appearance of an underlying condition in both patients.

The following cases were also shown:

Acute Neutrophilic Dermatosis
Dr P F Borrie

(1) **Ashy Dermatosis (Erythema Dyschromicum Perstans)**
(2) **Acrokeratosis Verruciformis of Hopf with Hypertrophic Lichen Planus**
Dr J L Verbov (for Dr P F Borrie)

(1) **Incontinentia Pigmenti**
(2) **Punch Grafts for Alopecia**
Dr D D Munro

Lichen Amyloidosis (Macular Type)
Dr E Abell (for Dr D D Munro)

Mycosis Fungoides (Tumour d'Emblée)
Dr Angus Macdonald (for Dr L Fry)

Hodgkin's Disease
Dr Angus Macdonald
(for Dr M Feiwel and Dr R Cairns)

Pityriasis Rubra Pilaris
Dr A Navaratnam (for Dr M Feiwel)

Generalized Telangiectasia
Dr A Navaratnam (for Dr L Fry)

Bullous Ichthyosiform Erythrodermia
Dr M L Johnson (for Dr H T H Wilson)