usually managed in the community with topical therapies and, if their psoriasis was generalized, only emollients were permitted; and many patients were lost to follow-up.

Despite prolonged photosensitivity with TMP-bath PUVA and 8-MOP bath PUVA, our impression from this study is that the second soak is probably important, though the size of the study did not allow us to reach a definitive conclusion.

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References


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Reactive Arthritis Associated with Chlamydia trachomatis Infection: Importance of Screening and Treating the Partner

Artritis reactiva por Chlamydia trachomatis: importancia del rastreo y tratamiento de la pareja

To the Editor:

Reactive arthritis, also known as Reiter syndrome, is a seronegative spondyloarthropathy classically defined by the triad of arthritis, urethritis, and conjunctivitis. It develops in the context of a gastrointestinal or genitourinary infection.1,2

The most common skin manifestations are circinate balanitis, keratoderma blenorrhagica, and nail dystrophy, but both the symptoms and their temporal relationship may vary.

We describe the case of a 23-year-old man admitted for sacroiliitis and psoriasiform lesions on the limbs and trunk associated with marked circinate balanitis, nail dystrophy, dactylitis, keratoderma blenorrhagica (Figure 1), asthenia, and bilateral conjunctivitis. The patient reported previous episodes of arthritis, conjunctivitis, and urethritis that occurred after an average incubation period of 3 weeks following symptoms of urethritis, and that improved after the administration of nonsteroidal anti-inflammatory drugs and doxycycline.

Blood tests performed during admission showed elevated levels of C-reactive protein. Rheumatoid factor was not elevated and the tests for autoimmunity, viral serology, and microbiology cultures for microorganisms related to sexually transmitted diseases were negative. Skin biopsy was compatible with psoriasis, the histocompatibility antigen study was positive for HLA-B27, and imaging studies revealed early signs of enthesitis and asymmetric sacroiliitis. The partner presented no genitourinary symptoms.

A sample of urethral exudate was taken from the patient and cervical exudate from the partner to test for Chlamydia

Figure 1 Keratoderma blenorrhagica on the right foot.
Testing and treatment for this infection must be undertaken in sexual partners, particularly in women in whom it may be asymptomatic, as in the present case. If the sexual partners are not treated, systematic reinfection will ensue with recurring outbreaks of reactive arthritis.

In those patients in whom the joint and skin manifestations are resistant to conventional therapy, methotrexate is an effective alternative, as occurred in this case. Molecular testing for *C. trachomatis* is more sensitive than cell culture, although cell culture is still the technique of choice in complementary tests for diagnosis of reactive arthritis.

Molecular biology techniques are currently recommended for the diagnosis of this agent in both European and US guidelines. Use of these tests with 2 different targets, as was performed in the partner of our patient, enables us to minimize the risk of finding false positives in populations with a low prevalence of this infection. It is also extremely important that doctors become familiar with the interpretation of these techniques for the detection of this bacterium.

**References**

Multiple Cutaneous Granular Cell Tumors
Tumores cutáneos múltiples de células granulares

To the Editor:

Granular cell tumor (GCT), described by Abrikossof in 1926, is a rare and usually benign neoplasm considered to be of neural origin. It usually presents as a solitary papule or nodule. Multiple cutaneous lesions such as those found in the case we present are very rarely reported in the literature.

Our patient was a 41-year-old white man with no relevant past history who, for 3 to 7 years, had had 4 slow-growing subcutaneous tumors of between 1.5 and 4 cm in diameter located on the left hip, the left iliac fossa, the right thigh (Figure 1), and the right scapular region. They were painful on palpation and not adherent to deep tissues. Magnetic resonance imaging showed that the lesions were located in the subcutaneous tissue and were independent of the fascia and underlying muscle (Figure 2). The skin biopsy showed a diffuse proliferation of polygonal cells with abundant granular eosinophilic cytoplasm packed with coarse, diastase-resistant, periodic acid-Schiff-positive granules that represent phagolysosomes. Immunohistochemistry reveals that a high percentage of granular cells are positive for S-100 (98-100%), neuron-specific enolase (98-100%), and vimentin (100%) and a lower percentage for CD57 (69%) and CD68 (65%).

Clinically, it is a firm, solitary, circumscribed, asymptomatic nodule that is usually less than 3 cm in diameter; it may be pruritic or painful. The diagnosis is not usually suspected clinically but depends on histology. Histology shows it to be an ill-defined, nonencapsulated tumor composed of sheets, nests or cords of rounded or polygonal cells with a small central nucleus and abundant eosinophilic cytoplasm packed with coarse, diastase-resistant, periodic acid-Schiff-positive granules that represent phagolysosomes. The overlying epidermis may be normal or show pseudoepitheliomatous hyperplasia.

The treatment of choice is simple excision of the entire lesion with adequate surgical margins. Radiotherapy and chemotherapy are not recommended.

References