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Bilharziasis cutanea tarda: A rare presentation of schistosomiasis

To the Editor: A 30-year-old male white student presented with a pruritic eruption on the groin and scrotum of 2 months duration. Previous treatments with topical antifungal and antiscabies agents and oral antibiotics brought no improvement, and the eruption continued to develop. Physical examination revealed grouped red papules and nodules, measuring up to 0.5 cm in diameter, on the groin and the scrotum (Fig 1) that were indurated and erythematous. There were no systemic symptoms. Histologic investigation of a punch biopsy specimen taken from a nodule revealed hyperplasia of the epidermis and heavy inflammatory infiltrate composed of lymphocytes, histiocytes, and eosinophils. An ovum with the characteristic terminal spines of *Schistosoma haematobium* was seen in the dermis (Fig 2). Light microscopic examination of a direct smear of the biopsy specimen without fixation or color staining disclosed a worm (Fig 3). The patient reported having swum several times in Lake Malawi in Africa a year and a half before the outbreak of skin lesions. He recalled no physical symptoms while in Africa.

No schistosoma eggs were found in the urine or feces. A complete blood cell count and chemistry panel showed an eosinophilia of 730 cells/µL (normal value <300), or 12.7% (normal 0%–7%). Erythrocyte sedimentation rate and biochemical tests of renal and liver function were normal. Serologic investigations were negative for schistosoma. Computed tomography of the chest and abdomen showed only mild lymphadenopathy of the left side of the groin.

Treatment with praziquantel, 20 mg/kg twice for 1 day, resulted in gradual flattening and fading of the skin eruption. A second skin biopsy specimen taken a month later from one of the remaining papules showed only fibrosis in the dermis with chronic inflammatory infiltrate. One more treatment with praziquantel for intense pruritus a month later re-
sulted in complete resolution of the skin lesions, with no recurrence after 4 months.

Diagnosis of this isolated skin manifestation of schistosomiasis without visceral disease is difficult. The lesions are not easily identified at clinical examination, and results of laboratory tests can be negative, leaving the diagnosis to the identification of schistosomal eggs. The ectopic deposition of ova within the dermis classified this case as the Bilharziasis cutanea tarda type. The finding of *S. haemato-
bium* eggs and worm in the perigenital area supports the putative mechanism that adult worms migrate from their normal habitats and travel against the current of the venous bloodstream to distant sites where they deposit their eggs in venules; indeed, adult worms have occasionally been found at ectopic sites.1

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X-linked ichthyosis in Southern Italy*

To the Editor: Few surveys on the frequency of X-linked ichthyosis (XLI) in large communities are available, and no study has been conducted in Italy. We report the frequency of X-linked ichthyosis in young men who enlisted as conscripts in the Italian navy.

Prior to enlistment, all potential conscripts aged 18 years and living in the coastal regions of southern Italy are examined at the Draft Council’s Medical Unit of the Italian Navy in Taranto. Subjects who show any pathologic condition are referred to our Navy Hospital. All the subjects referred to our department with an ichthyosiform condition underwent a thorough dermatologic examination and completed a questionnaire regarding their personal and familial history. From January 1998 through December 2000, 60,761 young men were examined at the Draft Council’s Medical Unit. Twelve cases of X-linked ichthyosis were diagnosed, with a frequency of 1:5,063 or 1.9 per 10,000 (95% confidence interval based on the Poisson distribution 1.0-2.8). All the patients had a family history confirming the X-linked inheritance. Three of 12 cases (25%) involved corneal opacities. No other significant associated pathologic change was observed.

In conclusion, the frequency of X-linked ichthyosis in southern Italy is roughly in agreement with estimates from other surveys, which range from 1:4,000 to 1:6,500.1–3 Corneal opacities have been regarded as a relevant clinical marker in the diagnosis of X-linked ichthyosis.4 We confirmed this finding, which was observed in about a quarter of our cases. X-linked ichthyosis has been associated with cryptorchidism;5, 6 however, none of our patients showed this pathologic change.

Although we did not measure the steroid sulfatase (steryl-sulfatase) activity in our patients,6,7 we believe the accuracy of physical examination, which involved a large male sample, homogeneous with reference to age, race, and country of origin, was such to yield sufficiently reliable data.

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