In conclusion, we report a second case of cutaneous multiple pseudolymphomas caused by *H. medicinalis* therapy. The diagnosis was confirmed by the clinical history, clinical features, histopathology and immunohistology. As medicinal leech therapy is becoming more popular in modern and alternative medicine, clinicians should be aware of potential complications such as pseudolymphoma.

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Recurrent Kaposi's varicelliform eruption successfully controlled by low-dose oral valaciclovir

Dear Editor,

Recurrent Kaposi's varicelliform eruption (r-KVE) is a rare skin condition characterized by multiple relapses of Kaposi's varicelliform eruption (KVE), also known as eczema herpeticum, with a positive serum titer for human herpes simplex virus (HSV).[1] Although r-KVE is a severe clinical condition, established treatment to prevent recurrence is not yet available. We report a case in which low-dose oral therapy with valaciclovir, an antiviral drug, successfully controlled r-KVE.

The patient was a 21-year-old Japanese man with a 15-year history of atopic dermatitis (AD) for which he had not received adequate treatment. He developed eruptions on the face, neck, groin and scrotum, and was referred to our department by a local dermatological clinic in November 2008. The eruptions were small ulcers with fine yellowish crusts that tended to coalesce (Fig. 1). Additionally, the patient also had typical AD, with dry skin on the whole body and eczematous lesions on the antecubital fossa. His body temperature was 37.2°C, and he experienced general fatigue. Blood analysis revealed an increase in eosinophils (white blood cells, 6290 cells/μL; eosinophils, 13.0%), and serum chemistry revealed the following findings: lactate dehydrogenase, 351 IU/L; C-reactive protein, 2.09 mg/dL; and total immunoglobulin (Ig)E, 15 420 U/mL. IgG and IgM titers to HSV were negative. He had no history of immunosuppressive disease. *Staphylococcus aureus* was detected in the bacterial culture from a facial lesion. A diagnosis of KVE was established.

He was hospitalized on the day of the diagnosis, and systemic treatment with antiviral and antibiotic drugs was initiated. His symptoms gradually resolved, and the treatment was switched to the standard treatment for AD based on the latest guidelines of the Japanese Dermatological Association.[2,3] He was discharged on the 12th day with mild symptoms of AD and was subsequently followed up at our outpatient clinic. Topical tacrolimus, which is known to induce KVE,[4,5] was not prescribed. Mild erythema on the whole face persisted, and topical steroid ointment was used intermittently when the dermatitis worsened. In addition, oral antihistamine and an emollient were used daily to maintain the condition of the face.

Kaposi's varicelliform eruption relapsed in January 2009, and the same treatment with systemic antiviral and antibiotic drugs was administrated in our ward. This time, the skin lesions of KVE were restricted to the face and the IgG titer was more than fourfold higher than that during the first attack (Table 1). After the second attack, continuous daily application of vidarabine ointment on the face was prescribed for prevention of r-KVE, in addition to the standard treatment for AD. Topical tacrolimus ointment for the facial eruption was tried on one occasion during the follow-up period, but it was discontinued as it caused irritation. Mild erythema on the face continuously persisted.

The third attack occurred in March 2009 and affected the facial skin; the same treatment was administrated again. After the condition resolved, treatment with oral valaciclovir (500 mg/day) was

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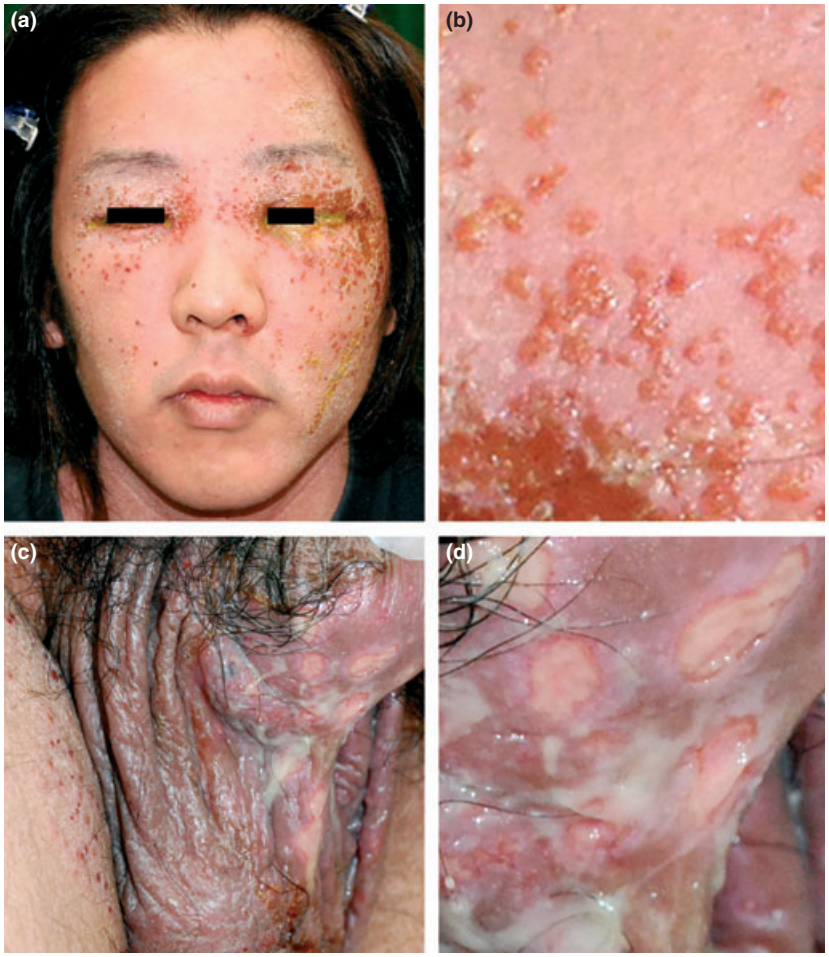

Figure 1. Skin lesions observed during the first attack. Small ulcers with a tendency to coalesce were seen on the face, neck, groin and scrotum. (a) Eruption on the face. (b) Close-up of the eruption on the left temple. (c) Eruption on the genital region. (d) Close-up of the eruption on the penis.

Table 1. Time-course of anti-HSV immunoglobulin titers (fluorescent antibody test)

	First attack (November 2008)	Second attack (January 2009)
HSV-IgG	<10×	40×
HSV-IgM	<10×	<10×

HSV, Herpes simplex virus; Ig, immunoglobulin.

initiated in addition to the oral antihistamine, emollients and steroid ointments. The mild erythema persisted. The patient continued the oral valaciclovir until May 2009 but stopped the treatment by himself because he thought that the disease was cured.

The fourth attack occurred in September 2009 with a broad distribution of small ulcers on the face, trunk and extremities. The same treatment was administrated in our ward. Thereafter, valaciclovir (500 mg/day) therapy was restarted. The patient continued the treatment until April 2010, and no recurrence was observed, although mild dermatitis on the face persisted.

Low-dose oral valaciclovir therapy is reported to be effective for the prophylaxis of recurrent genital HSV infection.[6,7] Therefore, we prescribed low-dose oral valaciclovir to our patient to suppress the recurrent HSV infection. In this patient, r-KVE recurred every 2 months until the third attack, and we consider that this is the natural interval of recurrence. After low-dose oral valaciclovir treatment was initiated, no recurrence occurred for a certain period and cease of intake led to the fourth attack. Moreover, continuous intake resulted in the patient being disease-free for 7 months. Therefore, we concluded that low-dose oral valaciclovir therapy successfully controlled r-KVE relapse, and low-dose oral valaciclovir should be considered for the prophylaxis of r-KVE.

The effect of topical immunomodulators in cases of r-KVE like the present case may be considered controversial. Clinical observations indicate that most r-KVE patients have continuous inflammation on the site, and immunomodulators such as tacrolimus can be a good choice to control the inflammation and thus prevent its recurrence. However, tacrolimus itself is known to induce KVE,[4,5] probably because of its immunosuppressant effect. We could not evaluate the efficacy of such drugs in our case,

because our trial of tacrolimus ointment was unsuccessful as it caused irritation. Further clinical trials with a large number of cases may reveal whether topical immunomodulators are beneficial in r-KVE or not.

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Secondary syphilis following tumor necrosis factor-α inhibitor treatment for rheumatoid arthritis

Dear Editor,

Patients with rheumatic diseases treated with tumor necrosis factor (TNF)-α inhibitors occasionally present with paradoxical cutaneous adverse effects, represented by psoriasiform or palmoplantar pustulosis-like eruptions.[1] The patient described here showed comparable psoriasiform eruptions during treatment with TNF-α inhibitors for rheumatoid arthritis, and she was assumed to have this adverse effect. Unexpectedly, she was later found to have secondary syphilis. TNF-α inhibitors may increase the risk of infections, but to the best of our knowledge, this is only the second case report on the occurrence of syphilis during TNF-α inhibitor treatment.

A 56-year-old woman with a 9-year history of refractory rheumatoid arthritis began etanercept at 25 mg/day twice weekly, in addition to methylprednisolone at 2–6 mg/day. She had elevated C-reactive protein (CRP; 1.29 mg/dL; normal <0.4 mg/dL), rheumatoid factor (52 IU/mL; normal <15 IU/mL), and low titer of antinuclear antibody (1:40), but specific autoantibodies were negative. A serological test for syphilis (STS) and the *Treponemal pallidum* hemagglutination assay (TPHA) test were both negative. Eleven months later, etanercept was switched to adalimumab at 40 mg biweekly due to insufficient efficacy. She noticed asymptomatic eruptions after the third injection of adalimumab. On physical examination, small, infiltrated, dark, erythematous macules were observed on both palms and soles, some of which exhibited scaling on the surface (Fig. 1a), while no obvious pustules were found. Regions of erythema coalesced on the lateral aspects of the soles with keratoderma. A biopsy specimen revealed psoriasiform elongation of rete ridges of the epidermis with slight acanthosis and hyperkeratosis. Inflammatory cell infiltration was observed mainly around dilated capillaries in the edematous reticular dermis; the majority of cells were lymphocytes, with no neutrophils, eosinophils or plasma cells found. The epidermis exhibited focal vacuolar

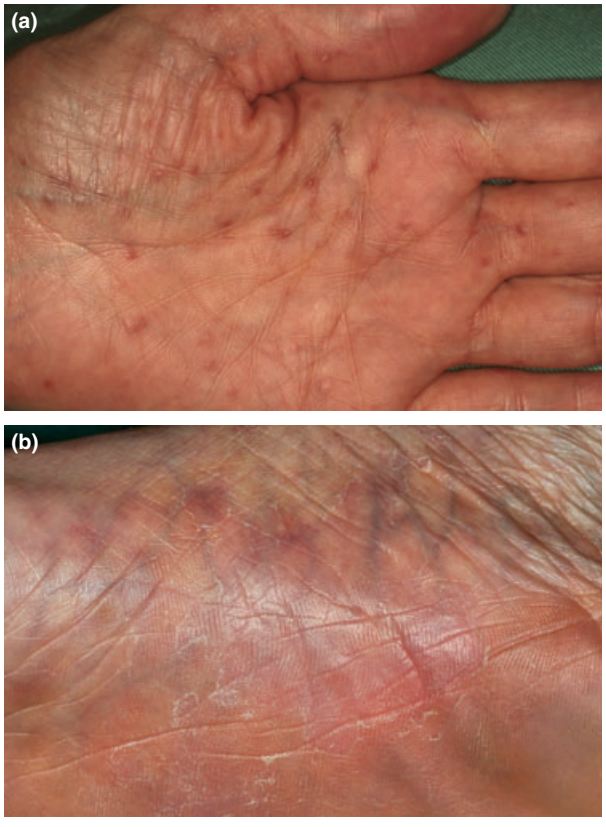

Figure 1. (a) Small maculopapular erythema on the palm after adalimumab administration. (b) Exacerbation of the eruption on the sole after infliximab administration.

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