

infants in Australia, although no adnexal polyps were noted (4). In Rohr's study, no histological examination was performed, so the skin tags he noticed might have been adnexal polyps of neonatal skin.

The histological findings matched those of the adnexal polyp; however, sebaceous glands and sweat glands were not identified. Only nests of squamous cells surrounded the follicles. For diagnosis, accessory auricles, skin tags, and supernumerary nipples (polythelia) should be considered. The accessory auricle is different from the adnexal polyp of neonatal skin histologically and clinically. In skin tags, skin appendages are not contained; skin tags can also appear in adults. Although polythelia is congenital and appears near the areola, smooth muscles and lactiferous ducts are characteristic histological features (5).

The unusual feature of our cases is the longer existence of the adnexal polyps. The adnexal polyp of neonatal skin is said to be easily removable using the fingertip, followed by bleeding. Within a week after birth, the tumors fall off spontaneously. It is reported that just one 26-day-old infant had a longer-lasting tumor (1). Our findings demonstrate that adnexal polyps can be present in infants older than one

week. The adnexal polyp of neonatal skin should be considered one of the small tumors seen on the trunk of infants, not only in neonates.

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Erythema Multiforme Combined with Legionellosis

Sir,

Infections often cause erythema multiforme, and more rarely, drugs are the cause. We describe a case of erythema multiforme occurring in the course of *Legionella pneumophila* (LP) infection.

CASE REPORT

A 56-year-old man was admitted for a febrile eruption, principally involving the buccal and genital areas, and cough. He was a chronic alcoholic and heavy smoker, and had alcoholic cirrhosis. In spite of antibiotic treatment (amoxicillin + clavulanic acid) for 5 days, fever persisted at 40°C.

Dermatologic examination showed crusted hemorrhagic lip erosions, oral erosions, and crusted erosions of the scrotum. Lung examination revealed cough, crepitations at the bases of both lungs, hypoxemia (pO₂: 74 mmHg), hypocapnia (pCO₂: 31 mmHg), and an interstitial syndrome on the chest X-ray. His general state of health had deteriorated, and he had mental confusion and epigastralgia.

Blood tests showed hyperleukocytosis (15 200/mm³ with 84% polymorphonuclear cells) and raised C-reactive protein (118 mg/l, normal <8 mg/l). Natriemia, creatininemia and liver function tests were normal. Blood and urine bacterial cultures were negative, and stool examination revealed no pathogens. Serodiagnosis for HIV, chlamydia, rickettsiosis, HSV and mycoplasma were negative or showed previous immunization. The first *Legionella pneumophila* serology was negative, and then seroconversion occurred (titre 1/128).

The patient was treated with spiramycin for 8 days, without success, and then with fluoroquinolon (ciprofloxacin 1 g/24h). Breathing difficulties disappeared after 3–4 days. The mucous lesions disappeared within 15 days.

DISCUSSION

The patient had erythema multiforme with mucosal involvement occurring in Legionnaire's disease. The diagnosis of

Legionella pneumophila infection was established on the basis of the breathing disorder, fever, pneumonia, chest X-ray and seroconversion for LP.

LP infection is only exceptionally linked with cutaneous lesions. In fact, only one case of cutaneous abscess has been described in an immunosuppressed patient (1), one case of pretibial rash (2), and one case of rash and renal failure (3). Only one other case of Legionnaire's disease combined with erythema multiforme has been described in a 3-year-old boy (also with seroconversion) (4).

The possibility of LP infection should be eliminated when erythema multiforme is combined with breathing disorder.

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