The history as well as the clinical and histological findings in our patient were fully consistent with the diagnosis MR.

In clinically inconclusive cases, such as ours, histological examination may give the diagnosis as the histopathological findings are distinctive. Therefore histological examination of synovium after synovectomy should be carried out in patients with arthritis of unknown cause.

The differential diagnoses regarding the arthritis are sero-positive rheumatoid arthritis, sero-negative polyarthritis, paraneoplastic arthritis and crystal arthritis, which may all be accompanied by skin nodules, whereas the described skin lesions may resemble granuloma annulare, histiocytoma and sarcoidosis.

The prognosis is clearly influenced by a possible underlying malignancy. In our case, malignancy has so far been excluded.

As regards the skin lesions, about one-half will clear completely or improve after a few years; the other half will remain stationary or progress. The arthritis remains stationary in 50%; in the other half it progresses and may result in crippling arthritis of the hands.

There is no adequate treatment for the disease.

REFERENCES

1. Beare, J. M. & Cunliffe, W. J.: Reticulohistiocytoma. *In* Textbook of Dermatology (ed. A. Rook, D. Wilkinson & F. Ebling). Blackwell Scientific Publications, Oxford, 1979.
2. Belaich, S.: Multicentric reticulohistiocytosis. G Ital Dermatol *115:* 77, 1980.
3. Buckley, C. A. & Bron, A. J.: Ocular and periocular features of multicentric reticulohistiocytosis with paraproteinaemia. A report of two cases. Trans Ophthalmol Soc NZ *33:* 143, 1981.
4. Caputo, R., Alessi, E. & Berti, E.: Collagen phagocytosis in multicentric reticulohistiocytosis. J Invest Dermatol *76* (5): 342, 1981.
5. Catterall, M. D.: Multicentric reticulohistiocytosis. A review of eight cases. Clin Exp Dermatol *5* (3): 267, 1980.
6. Coode, P. E., Ridgway, H. & Jones, D. B.: Multicentric reticulohistiocytosis. Report of two cases with ultrastructure, tissue culture and immunology studies. Clin Exp Dermatol *5* (3): 281, 1980.
7. Krey, P. R., Comerford, S. R. & Cohen, A. S.: Multicentric reticulohistiocytosis. Fine structural analysis of the synovium and synovial fluid cells. Arthritis and Rheumatism *17* (5): 615, 1974.
8. Krmpotic, L., Marghescu, S., von Wilmowsky, H. & Freyschmidt, J.: Multizentrische Retikulohistiozytose. Hautarzt *31* (7): 384, 1980.
9. Orkin, M. Goltz, R. W., Good, R. A., Michael, A. & Fisher, I.: A study of multicentric reticulohistiocytosis. Arch Dermatol *89:* 640, 1964.
10. Tani, M. et al.: Multicentric reticulohistiocytosis. Electron microscopic and ultracytochemical studies. Arch Dermatol *117* (8): 495, 1981.

Atopic Dermatitis and Hodgkin's Disease

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Received June 21, 1982

Abstract. Five patients with atopic dermatitis developed Hodgkin's disease. This rare clinical occurrence was discovered when adenopathy revealed Hodgkin's granuloma in a biopsy specimen, thus adenopathy in chronic atopic dermatitis should not be dismissed casually.

Because atopy occurs so frequently in the general population, its concurrence with other abnormalities may be expected. However, two coexisting phenomena can influence one another. This appeared to be so in the study of atopy and Hodgkin's disease by Amlot & Green (1). These authors studied 115 patients who had active Hodgkin's disease. The patients with Hodgkin's disease and a high IgE serum concentration were separated into atopic and non-atopic groups. In the atopic patients, the IgE levels were not influenced by treatment, whereas in the non-atopic patients, the IgE levels decreased with successful therapy of the Hodgkin's disease.

No relationship of elevated IgE level to duration of remission or life expectancy in Hodgkin's disease has been observed. Atopic patients were different clinically, having less fever and feverish night sweatings and less loss of weight.

CASE REPORTS

We have analysed the patient material of the Mayo Clinic between 1954 and 1979 and discovered 5 cases of atopic dermatitis and Hodgkin's disease. The essential data of these cases are summarized in Table I.

Table I. *Patients with atopic dermatitis and Hodgkin's disease*

Case no.	Sex	Age at onset: Atopic dermatitis	Age at onset: Hodgkin's disease (yr of age)	Other signs/symptoms	Previous treatment	Type of Hodgkin's disease	Outcome
1	f	Early childhood	68	Asthma	Steroids	Granuloma	Dead, 1 yr
2	f	Early childhood	32	Urticaria; hay fever		Granuloma	Dead, 1 yr
3	m	16 yr	30		X-ray to skin	Granuloma	Dead, 1 yr
4	f	Postnatal	24	Verrucae; thrombophlebitis		Granuloma	Dead, 8 yr
5	m	8 yr	24	Hay fever/nocturnal sweatings, loss of weight	X-ray to skin	Granuloma	Dead, 5 yr

DISCUSSION

The findings in our 5 patients were remarkably uniform. Only one had fever, loss of weight and nucturnal sweatings. Four of these patients were young adults in whom adenopathy developed in addition to their atopic dermatitis. The symptoms and dermatitis responded only to steroid therapy. Elevated sedimentation rates and eosinophilia were sporadic associated findings. All 5 patients had granulomatous Hodgkin's disease, equivalent to nodular sclerosis and mixed cellularity in the current literature (2).

The concurrence of atopic dermatitis and Hodgkin's disease is uncommon. In the series of Amlot & Green (1) of 15 patients with Hodgkin's disease, 8 had atopy and only 2 of these had atopic dermatitis. However, their and our quoted cases raise the question whether chronic (atopic) dermatitis may evolve into lymphoproliferative disease. Degos (3) showed a relationship of dermatitis to mycosis fungoides and we have demonstrated a possible relationship between atopic dermatitis and Seżary's syndrome (Rajka & Winkelmann, 5). Amlot & Green did not find any relationship between other forms of lymphoma and atopy, but they did not study cutaneous lymphoma (1).

There is no direct evidence that atopic dermatitis either shields from or predisposes to tumour proliferation. A connecting such factor may be the reduced cell-mediated immunity (4) or presence of immunodeficiency in severe atopic dermatitis (6). It may be speculated that in non-atopic patients with Hodgkin's disease, mycosis fungoides, or Seżary's syndrome, the elevated IgE values may represent a direct stimulation of the IgE antibody system, a loss of T suppressor cell effect upon it, or a T helper cell effect. These mechanisms, especially the first two mentioned, might be operative also in our cases of atopic dermatitis with Hodgkin's disease.

The practical consequence of our findings is that adenopathy in chronic atopic dermatitis should not be dismissed casually.

REFERENCES

1. Amlot, P. L. & Green, L. A.: Atopy and immunoglobulin E concentrations in Hodgkin's disease and other lymphomas. Br Med J *i:* 327, 1978.
2. Bluefarb, S. M. & Caro, W. A.: Lymphomas and leukemias of the skin. *In* Cancer of the Skin: Biology, Diagnosis, Management, vol. 2 (ed. R. Andrade, S. L. Gumport, G. L. Popkin and T. D. Rees), p. 1226. W. B. Saunders Company, Philadelphia, 1976.
3. Degos, R.: Dermatologie. Flammarion, Paris, 1953.
4. Rajka, G.: Delayed dermal and epicutaneous reactivity in atopic dermatitis (prurigo Besnier). I. Delayed reactivity to bacterial and mold allergens. Acta Dermatovener (Stockholm) *47:* 158, 1967.
5. Rajka, G. & Winkelmann, R. K. (submitted for publication). Atopic dermatitis and Sézary's syndrome.
6. Rogge, J. L. & Hanifin, J. M.: Immunodeficiencies in severe atopic dermatitis: depressed chemotaxis and lymphocyte transformation. Arch Dermatol *112:* 1391, 1976.

Nevus Oligemicus with Sensory Changes

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Received July 22, 1982

Abstract. After a cold bath a 16-year-old man developed livid erythema with hot anesthesia on the trunk and arm, with unilateral topography. A similar case was previously