type of proliferative vascular growth within noninvoluting, high-flow anomalies may prompt earlier treatment. Further study may provide clues regarding the pathogenesis and treatment of high-flow vascular growths and of proliferative lesions arising in this context.

Benjamin Barrick, DO
Julia Lehman, MD
Megha Tollefson, MD

**Author Affiliations:** Department of Internal Medicine, Mayo Clinic, Rochester, Minnesota (Barrick); Department of Dermatology, Mayo Clinic, Rochester, Minnesota (Lehman, Tollefson).

**Corresponding Author:** Megha Tollefson, MD, Department of Dermatology, Mayo Clinic, 200 First St SW, Rochester, MN 55905 (Tollefson.megha@mayo.edu).

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**Diffuse Cutaneous Pseudolymphoma Due to Therapy With Medicinal Leeches**

Primary cutaneous B-cell lymphoma and B-cell pseudolymphoma may show similar clinical and microscopic presentations and sometimes represent a real diagnostic challenge for both clinician and pathologist.1

**Report of a Case** A woman on her 50s presented with a 6-month history of multiple, firm, reddish, pruritic and excoriated papules and nodules extensively distributed on the back (Figure 1). The patient was otherwise healthy, with a medical history of only fibromyalgia, and both clinical examination and blood test findings were unremarkable.

Histologic examination of 2 punch biopsy specimens taken from the nodules on the back showed a prominent dermal nodular lymphoid infiltrate with germinal centers surrounded by a dense infiltrate composed of small round lymphocytes, histiocytes, mature plasma cells, eosinophils, and a smaller percentage of larger centrocyte-like cells (Figure 2). Most of the cells in the infiltrate were positive for the pan-B cell markers CD20 and CD79a. The cells in the germinal centers were also positive for CD10 and BCL2 and negative for BCL6. The small lymphocytes in the infiltrate were positive for CD3. On the basis of the overall histologic findings, a working diagnosis of primary cutaneous B-cell lymphoma of marginal zone was initially considered, but the histologic specimens were subsequently referred for a second opinion to an expert dermatopathologist. The histologic review suggested a possible differential diagnosis of cutaneous pseudolymphoma mimicking a marginal zone lymphoma, further supported by the absence of light-chain restriction by in situ hybridization.

Questioning the patient again revealed that 5 or 6 weeks prior to the onset of the skin eruption, she had undergone a course of natural therapy for chronic fibromyalgia that involved applying medicinal leeches (Hirudo medicinalis). Therefore, a favored diagnosis of pseudolymphoma secondary to the application of leeches was made.
The patient began treatment with topical metomatoxone furoate, applied twice daily, and complete resolution of the skin eruption was seen after 3 to 4 weeks. A monthly clinical follow-up program was subsequently commenced, and the patient had no recurrence of any inflammatory papule or nodule nor clinical or biochemical evidence of lymphoma after 15 months.

Discussion | The term pseudolymphoma designates a group of reactive lymphocytic disorders that involve an inflammatory response to known or unknown stimuli simulating malignant lymphomas both clinically and histologically.2 To our knowledge only 2 cases of cutaneous multiple pseudolymphomas induced by H. medicinalis have been reported.3,4 Smolle et al3 described multiple pseudolymphomas on the lower legs of a woman receiving leech therapy for venous insufficiency. More recently, Choi and Kim4 reported a similar case on the lower legs of a Japanese man who had infraorbital dark circles treated with H. medicinalis.

Medicinal leeches have historically been used as a non-conventional treatment for chronic venous insufficiency and are now frequently used in plastic surgery.5,6 In addition, less common applications such as osteoarthritis, muscular pains, or injuries have been reported.6

In conclusion, with the increasing popularity of traditional and alternative medicine, H. medicinalis therapy is becoming increasingly popular, and we all need to be aware that pseudolymphoma represents a possible complication in this type of treatment.

Davide Altamura, MD
Eduardo Calonje, MD, DIP, RCPath
Jia li Liau, MD
Martyn Rogers, MD
Roberto Verdolini, MD, FRCP

Author Affiliations: Department of Dermatology, The Princess Alexandra Hospital Trust, Harlow, Essex, England (Altamura, Liau, Rogers, Verdolini); Department of Dermatopathology, St John’s Institute of Dermatology, Guy’s and St Thomas’ Hospital Trust, London, England (Calonje).

Corresponding Author: Davide Altamura, MD, Department of Dermatology, The Princess Alexandra Hospital Trust, Harlow, Essex CM20 1UX, England (Davide.Altamura@pah.nhs.uk).

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Fingertip Purpura in a Dental Student: An Unusual Manifestation of Methyl Methacrylate Dermatitis

Methyl methacrylate (MMA) is a well-known sensitizer commonly found in dental resins, bonding agents, prosthetics, artificial nail adhesive, and industrial glues. Allergic contact dermatitis due to MMA is often seen in individuals with occupational exposure, such as those in the dental profession.

Report of a Case | A healthy dental student in her 20s with allergies to silver, nickel, and wool presented with pruritus, pain, blistering, swelling, and numbness of the first 3 digits on her left hand. One month earlier, she had presented to her primary care physician for intense pruritus and vesicles on the left hand. Despite treatment with topical steroids for presumed eczema, her symptoms worsened, forcing her to reschedule her practical examination and present to an outside emergency department (ED) where she was treated for presumed herpetic whitlow with a 7-day course of acyclovir. Her symptoms ultimately resolved.

After resuming preparations for her practical examination, she experienced a rapid relapse of her symptoms, prompting presentation to our ED. She reported extensive handling of plastic models of teeth, and 2 months prior to her initial presentation at her primary care physician, she had begun using a new brand of powder and liquid crown resin while fashioning mold impressions of teeth. Wearing nitrile gloves, she would hold the mold with the first 3 digits of her left hand while applying the resin with her right hand.

On physical examination, we found mild edema and erythema and superficial desquamation along the palmar surfaces of the first, second, and third digits of the left hand, corresponding to areas of contact with the mold. A prominent purpuric patch with a larger area of desquamation was present distally on the first digit (Figure).

Review of the resin ingredients revealed that the liquid compound contained 60% to 100% MMA, whereas the powder contained only nonsensitizing agents.1 Given the delay in the patient’s symptoms with initial use of the resin followed by a rapid relapse with reexposure as well as her history of intense pruritus, she was diagnosed as having allergic purpuric contact dermatitis (PCD) in reaction to MMA. She was treated with betamethasone, 0.05%, ointment and prednisone, 20 mg, orally for 5 days. She was instructed to discontinue using the resin.

At 10-day follow-up, her skin was clear. Patch testing was deferred in consideration of symptom resolution, a high degree of confidence in having eliminated the triggering agent, and her imminent practical final examination. She was instructed to wear 2 layers of nitrile gloves with petroleum between them if further contact with MMA was anticipated, with glove changes every 30 minutes to minimize exposure.

Discussion | An acrylic monomer, MMA can permeate latex gloves within 1 minute and nitrile gloves within 3 minutes.7 “Double gloving” does not effectively decrease MMA permeability, but the addition of a layer between pairs of glove, such as water, may decrease permeability 4-fold.2 A synthetic lami-