formed. The exanthema and the eosinophilia decreased gradually until normalization was achieved on day 16.

On day 19, vemurafenib therapy was discontinued, and within 7 days thereafter, the fever had improved, and the electrolyte profile had normalized. Tumor assessment showed a major tumoral response.

On day 29, vemurafenib treatment was restarted at half dose, leading within 21 days (day 50) to a relapse of hypokalemia and hypouricemia with acute urinary loss but without relapse of fever, exanthema, or eosinophilia. Vemurafenib treatment was then definitively stopped, followed by normalization of electrolytic findings within 5 days. At that time, treatment with dabrafenib, another BRAF inhibitor, was started. At last follow-up 5 months later, no adverse event had occurred.

Discussion | To our knowledge, this is the first case of Fanconi syndrome associated with vemurafenib. Fanconi syndrome is characterized by a generalized transport defect in the proximal tubules leading to renal losses of potassium, phosphate, uric acid, glucose, amino acids, bicarbonates, and/or low-molecular-weight proteins. Not all of these losses occurred in our case, as they do not in most cases, but we did observe abnormal losses of potassium, phosphate, and uric acid.

Three recent studies2-4 have reported vemurafenib-induced nephrotoxic effects in 27 cases, most of these showing a moderate decrease in GFR (30%-35%) within the first month of treatment. Mild proteinuria occurred in 10 of 24

cases,2-4 and various cutaneous toxic effects in 7 of 12 cases. A kidney biopsy was performed in only 1 case of severe renal dysfunction, revealing acute tubular necrosis. Mechanisms remain unclear; specific tubular toxic effects2 and acute immunologic interstitial nephritis3 are possible explanations.

In our case, there was no decrease in GFR, but Fanconi syndrome occurred, which suggests that vemurafenib exerts tubular toxic effects. The chronicologic sequence from initiation of vemurafenib treatment to the onset of Fanconi syndrome (Figure) and the absence of other evidence of tubular defects strongly suggest a drug-induced mechanism, as has been reported with other toxic effects.5

Our patient also presented some features of DRESS (drug reaction with eosinophilia and systemic symptoms): fever, eosinophilia, and atypical lymphocytes. However, evaluating according to the Kardaun criteria established by the European Regiscar group,6 we found a score of 2. To our knowledge, Fanconi syndrome has never been associated with these clinical features. Moreover, only the biological anomalies relapsed when vemurafenib was reintroduced. This may suggest that the 2 manifestations are not related and should be considered different sets of adverse effects.

We recommend regular monitoring of blood electrolyte profiles in vemurafenib-treated patients. If Fanconi syndrome occurs, discontinuation of vemurafenib treatment and initiation of treatment with a different BRAF inhibitor should be considered.

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Moon Jellyfish Stings

Envenomation by jellyfish is a common occurrence affecting millions of individuals yearly. Little literature exists on jellyfish stings caused by the “moon jellyfish,” Aurelia aurita. The main objective of the present report is to illustrate that A aurita stings are not as benign as once thought and to propose a treatment sequence for jellyfish stings to address the local cutaneous reactions that these stings can cause.
Report of a Case | A healthy 25-year-old white man was stung on the right wrist and forearm while scuba diving at night off of Fort Lauderdale, Florida. Images of the jellyfish were captured by an underwater camera and compared with reference images to confirm the species as *A. aurita*, otherwise known as the moon jellyfish. Of note, these particular specimens were quite large compared with ones more frequently seen. Contact with the jellyfish led to intense stinging pain followed by subsequent pruritus and the formation of urticaria after a few minutes that persisted for several hours (Figure, A).

Initial treatment aimed at removal of nematocysts followed by control of pain and pruritus. Within a few minutes of being stung, the area was exfoliated with sand mixed with seawater to remove nematocysts. Subsequently, the forearm and wrist area was soaked in warm acidic white vinegar, 5%, solution for half an hour to remove remaining nematocysts. Use of vinegar has been purported to block the discharge of nematocysts in other species of jellyfish, although reports are conflicting.1 Ibuprofen, 500 mg twice daily, was taken as an analgesic for the first 2 days.

The second step involved mitigation of the urticarial reaction and reduction of pruritus. Hydrocortisone has been shown to relieve pain and reduce inflammation due to stings from other species of jellyfish but has not been shown to treat *A aurita* stings.2 A topical hydrocortisone, 1%, cream was applied to the affected area 3 times daily to control pain and inflammation. Six hours after the initial sting, vesiculopapular erythematous areas were noted, with a coalescence of vesicles over the area most affected by day 2 (Figure, B and C). Vesicles persisted until the third day and subsequently ruptured.

The area was then treated with the topical triple antibiotic combination of bacitracin zinc, neomycin sulfate, and polymyxin B sulfate 3 times daily for 3 days, and steroid applications were discontinued. Scabbing was noted shortly after rupture of the vesicles that healed with time (Figure, D and E).

After discontinuation of treatment with the triple antibiotic ointment, a pea-sized amount of aloe vera gel was applied to the affected area to soothe residual irritation. The lesions resolved by day 8 (Figure, F), 2 days sooner than reported in a case where no treatment was given3 and in a study where purified venom was applied directly to the skin.4

Discussion | An in vitro study has shown that *A aurita* toxin can be both hemolytic and proteolytic to human cells.5 This has led to the assertion that although the vast majority of *A aurita* individuals in a particular area are innocuous, some may cause harm to humans. Herein and in an earlier report of a moon jellyfish sting,3 it was noted that the stinging animals were quite large for the species. Larger jellyfish contain larger cnidoblasts, which house the stinging nematocysts, and the larger nematocysts may penetrate the human epidermis sufficiently, unlike those of smaller specimens, to cause a local dermatologic reaction at the site of exposure.

The course of *A aurita* stings involves an intense pruritic vesiculopapular erythematous eruption that lasts 10 days without intervention. However, with the use of readily available
over-the-counter medications and common household ingredients, the sequelae of *A aurita* stings can be managed effectively, allowing the lesions to clear earlier.

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**High-Dynamic-Range Dermoscopy Imaging and Diagnosis of Hypopigmented Skin Cancers**

Acquiring digital dermoscopy images has become routine practice in the offices of many dermatologists around the world. While the main purposes of acquiring digital dermoscopy images are documentation and short- and long-term monitoring, these images can be enhanced to magnify features or sharpen contrast, making it easier to better visualize dermoscopic structures that are otherwise not as conspicuous. The photographic technique known as high-dynamic-range (HDR) imaging, a digital technique that produces a greater dynamic range (DR) of luminosity across the image than standard imaging, can enhance some dermoscopic structures.

In digital photography, DR describes the ratio between the maximum and minimum of detectable light intensities. It is measured in exposure value (EV) differences (known as stops) between the brightest and darkest parts of the image that show detail. An increase of 1 EV represents a doubling of the light intensity. The DR of the human eye is 6.5 EVs. Modern digital cameras have a DR up to 14 EVs, which is far superior to that of the human eye.

High-dynamic-range images are normally produced by capturing multiple standard photographs at different exposure settings: One image is taken underexposed (too dark), another with normal exposure, and a third overexposed (too bright). These images are subsequently combined to form a single image with a broader tonal range.

Dermoscopy attachments for mobile phones are now readily available and are already widely used for routine documentation purposes. While HDR image acquisition was previously relegated to only high-end digital single-lens-reflex cameras, the new generation of mobile phones is now able to acquire good-quality HDR images. Thus, it is now possible to effortlessly capture HDR images by simply turning on the HDR mode in the camera settings on their mobile phone.

**Report of Case**  
To illustrate the usefulness of HDR dermoscopy, we present the case of a patient with a hypopigmented macule of unknown duration located on the back. A standard equipment and techniques as in panel A but with the camera’s HDR mode turned on. The diagnostic dermoscopy criteria such as spoke wheel-like structures and leaflike areas as well as the blood vessels appear more conspicuous than by conventional dermoscopy and can be easily identified.