had larger, irregularly shaped ulcerations with a fibrinous base on her legs.

Blood and skin cultures grew MRSA that was sensitive to trimethoprim-sulfamethoxazole, vancomycin, linezolid, and daptomycin. Findings of polymerase chain reaction (PCR) studies of cutaneous ulcerations were negative for varicella zoster virus and HSV. A punch biopsy of a cutaneous ulcer revealed epidermal atrophy, papillary dermal edema, and perivascular and interstitial mixed inflammation. Scattered endothelial cells in small dermal vessels and dermal fibroblasts showed large eosinophilic intranuclear inclusions surrounded by a clear halo (Figure 2). Immunohistochemical stains for CMV highlighted several endothelial cells and fibroblasts (Figure 2, inset). No PCR testing for CMV was performed on skin specimens because the positive immunohistochemical findings were considered confirmatory. Cytomegalovirus DNA was detected by plasma PCR.

She was diagnosed with disseminated cutaneous CMV infection with CMV viremia. There was no evidence of other organ involvement or of further progression of her MF or hematologic disease. Treatment with TEBE was discontinued, and she completed 3 weeks of treatment with intravenous ganciclovir and vancomycin followed by resolution of her cutaneous ulcerations. Subsequent plasma CMV PCR findings were negative, and she was discharged home.

Discussion | Systemic CMV infection in immunocompromised patients may present a wide range of cutaneous manifestations, including ulcers (classically perianal), purpuric eruptions, morbilliform eruptions, vesiculobullous eruptions, and necrotic papules.1,2 Isotopic immune responses are not commonly associated with CMV, although 1 report describes a chronic CMV infection developing along herpes zoster scars in a patient with human immunodeficiency virus.3 In our patient, the CMV infection presented in a widely disseminated cutaneous fashion after initiation of TEBE irradiation similar to what is seen in eczema herpeticum—a condition causally linked to HSV but not CMV. The TEBE irradiation could possibly have been the inciting factor that reactivated a latent CMV infection and induced a disseminated cutaneous eruption.

It is important to remember that coinfections frequently occur with CMV, and these must be included in the differential diagnoses even in the presence of another infectious diagnosis that can seemingly explain the cutaneous findings. In this case, our patient had a history of recurrent cutaneous HSV and grew MRSA from both skin and blood. Identification of this condition is important: although cutaneous CMV is rare, it can portend a poor prognosis and be a leading sign of systemic infection.5

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Oral Malignant Acanthosis Nigricans and Tripe Palms Associated With Renal Urothelial Carcinoma
Malignant acanthosis nigricans (AN) is an uncommon paraneoplastic condition that can involve oral mucosa. Though usually associated with gastric carcinoma, associations with tripe palms and, more rarely, other carcinomas are possible.

Report of a Case | A 70-year-old woman reported sudden warty growths over the lips with oral discomfort and difficulty eat-
ing. She had a 6-month history of vague abdominal discomfort. Examination showed extensive papillomatosis over the lips, tongue, and palate (Figure 1). There were verrucous, velvety pigmented plaques in the axillae, posterior neck, periumbilical region, and groin folds. Her palms had a ridged appearance and coarse texture (Figure 2). Clinical diagnosis of tripe palms and malignant AN with significant oral involvement was made.

Abdominal computed tomography (CT) showed a large left-sided renal mass with retroperitoneal lymphadenopathy. A radiologically guided biopsy of this mass revealed invasive carcinoma with focal squamous differentiation favoring a urothelial primary. Thorax CT showed necrotic mediastinal lymphadenopathy causing superior vena cava (SVC) compression. She was treated for stage IV invasive renal urothelial carcinoma and underwent 5 cycles of radiotherapy to the mediastinum to prevent SVC obstruction.

The oral discomfort persisted, and she was unable to eat. Palliative chemotherapy with cisplatin and gemcitabine was started. She was also treated with oral acitretin, 10 mg/d, with minimal improvement. After 4 weeks, the dose was increased to 20 mg/d, and 8 weeks later, her symptoms had significantly improved. At last follow-up, she was tolerating palliative chemotherapy as well as oral acitretin.

Discussion | Tripe palms is sometimes considered to be a manifestation of AN on the palms.1 It may occur on its own and is commonly associated with lung carcinoma.1 When it coexists with malignant AN, the most frequently associated cancer is gastric carcinoma. Affected patients present with thickened palms and exaggerated dermatoglyphics with diffuse ridging.

Unlike its benign counterparts, malignant AN is rare. It is abrupt in onset and frequently associated with gastric adenocarcinoma.1 Oral involvement can occur in about 40% of cases with malignant AN, usually affecting the lips, tongue, and buccal mucosa.2,3 Pharyngeal and esophageal involvement may result in debilitating symptoms for patients undergoing chemotherapy.

Like most paraneoplastic dermatoses, malignant AN runs a parallel course with the underlying cancer and is expected to improve with successful treatment of that cancer. However, specific treatment options for oral AN are limited, especially for patients with advanced carcinomas with poor prognosis. Nomachi et al4 described a case of improvement of oral lesions following successful treatment of lung adenocarcinoma with chemotherapy. Another report described using methotrexate in a man with advanced gastric adenocarcinoma and florid oral AN, but he died of cancer-associated complications shortly after commencing methotrexate therapy.3 Therapeutic success with carbon dioxide laser ablation has been reported in a patient with cervical cancer who develope...
oped persistent lip plaques despite successful oncological treatment. Others report the use of retinoids for its keratolytic effects, but with varying outcomes due to the underlying cancer. Only 1 other case has described improvement in oral lesions with systemic retinoids. This patient had metastatic gastric carcinoma but was eventually lost to follow-up.

To our knowledge, this is the first report of oral malignant AN and tripe palms occurring in association with invasive renal urothelial carcinoma. Despite palliative chemotherapy, the patient’s oral symptoms persisted and only improved after 8 weeks of acitretin treatment. A palliative approach was adopted with the aim of improving her eating ability and nutritional status.

In malignant AN, successful treatment of the underlying cancer results in improvement of cutaneous or oral signs. We wish to highlight that systemic retinoids can be considered for symptomatic relief in patients with metastatic or late-stage carcinomas, thereby improving nutritional status and quality of life.

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Cutaneous Infection Caused by Plant Pathogen Colletotrichum gloeosporioides

Colletotrichum species are common pathogens for plant anthracnose but have recently emerged as a human opportunistic pathogen causing keratitis and subcutaneous fungal infection, which potentially can lead to life-threatening systemic dissemination. Therefore, early recognition and intervention with debridement and systemic antifungal treatment are required to reduce the morbidity and mortality. Herein we described a case of cutaneous fungal infection by Colletotrichum gloeosporioides.

Report of a Case | A woman in her 70s with a history of recurrent stasis dermatitis treated with long-term topical and systemic corticosteroids presented to the clinic with painful swelling over the right lower leg of 1 week’s duration. On physical examination, there were necrotic ulcers covered by hemorrhagic crusts and purulent debris on the right lower leg (Figure, A). She was afebrile. The blood tests revealed elevated C-reactive protein (18.1 mg/L) but no leukocytosis.

Histopathologically, the tissue fragments showed necrosis of the dermal and superficial subcutaneous tissue with a dense mixed inflammatory cell infiltrate and necrotic occlusion of blood vessels. Periodic acid-Schiff stain revealed abundant thin, septate hyphae on the base of the ulcer and in the lumen of necrotic blood vessels. Fontana-Masson stain revealed no pigmentation of the fungal elements (Figure, B). Fusgal culture of the necrotic tissue from the ulcers grew colonies with white aerial mycelia, cylindrical conidia, and pigmented clavate appressoria (Figure, C).

Sequence analysis and a National Library of Medicine BLAST search revealed that the isolate had sequence similar