for the negative control emulsifying ointment. Even when we excluded the 2 patients with previously documented resistance from the analysis, we found that the trend for increasing ivermectin survival time remained significant ($P=.006$) (Table). Results from a single patient with recurrent CS and previously documented ivermectin resistance are of note (Figure). When this patient was treated again in 2006 with 3 doses of ivermectin (200 µg/kg), no noticeable reduction in mite numbers was observed (unpublished observations). A significant increase in mite survival time was observed when mites collected after 8 days and 3 doses of ivermectin were compared with those collected prior to the commencement of ivermectin therapy ($P=.003$).

**Comment.** Mite survival times in the presence of in vitro ivermectin doubled over the 10-year study period. Furthermore, sequential data collected from a single patient over a course of ivermectin treatment confirms that selection for ivermectin-tolerant mites can occur rapidly and persist once established. These observations support concerns regarding the sustainability of mass drug administration scabies control programs using ivermectin. Surveillance of CS is important, not only to the individual but also to the community as a whole. As ordinary and crusted scabies are caused by the same variety of mite, patients with CS serve as core transmitters in many communities and may limit the success of community control programs. We are concerned by the potential for core transmitters serving as reservoirs of mites with increasing ivermectin tolerance, thus threatening the success of mass drug administration programs based on ivermectin.

Increased monitoring for the development of drug resistance is urgently needed within the community setting. Because the applications of in vitro assays are limited, the development of molecular-based diagnostic techniques that are more sensitive and amenable to community application is imperative. It should also be recognized in Australian Aboriginal communities and elsewhere that addressing the underlying causes of persisting high rates of scabies (eg, overcrowding, socioeconomic disadvantage, poor sanitation facilities) will effect a broader improvement in health as well as assist in control of scabies.

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**Acquired Lymphangiectasia Associated With Treatment for Preceding Malignant Neoplasm: A Retrospective Series of 73 Japanese Patients**

Acquired lymphangiectasia (AL), previously called acquired lymphangiomata, was first described in 1956 by Plotnick and Richfield as a complication of radical mastectomy. Like lymphangiosarcoma, which may arise as a complication of chronic lymphedema, AL mainly occurs after surgery and radiation therapy for malignant neoplasms such as breast carcino-

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**Figure.** Kaplan-Meier survival analysis of mites exposed to ivermectin. The data were collected from a patient with recurrent crusted scabies during an 8-day treatment regimen in 2006 and show significantly increasing median survival times ($P=.003$ by treatment day 8) over the course of ivermectin treatment, indicating selection for subpopulations of ivermectin-tolerant mites. "n" indicates number of mites used in each in vitro assay.
Table. Relation Between Therapy for Preceding Diseases and Time to Develop Acquired Lymphangiectasia

<table>
<thead>
<tr>
<th>Therapy for Preceding Diseases</th>
<th>Patients, No. (%)</th>
<th>Latent Period, Mean (SD), y</th>
<th>P Valuea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>8 (18.2)</td>
<td>16.3 (12.2)</td>
<td>.87</td>
</tr>
<tr>
<td>Irradiation</td>
<td>2 (4.5)</td>
<td>14.7 (11.8)</td>
<td>.20</td>
</tr>
<tr>
<td>Surgery and irradiation</td>
<td>34 (77.3)</td>
<td>10.3 (5.6)</td>
<td>.001</td>
</tr>
<tr>
<td>No LND</td>
<td>26 (59.1)</td>
<td>12.4 (4.9)</td>
<td>.001</td>
</tr>
<tr>
<td>LND</td>
<td>8 (18.2)</td>
<td>3.7 (2.4)</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: LND, lymph node dissection.

a Mean latent periods for the appearance of acquired lymphangiectasia were statistically assessed using the Welch t test. The latent period in patients who were treated with LND was significantly shorter than that in patients who were not treated with LND among the group in which combination therapy (surgery and irradiation) was performed.

ma4 and uterine carcinoma,5 which suggests that these therapies might cause AL. In addition, the period from the preceding illness to the development of AL varies. The present study investigates the relationship between therapy and the onset of AL.

Methods. Seventy-three cases of AL in Japan were investigated. The mean latent period before the appearance of AL was statistically assessed using the Welch t test in relevance to therapies the patients underwent: surgery, irradiation, or both. We also examined the relationship of lymph node dissection (LND) to the development of AL.

Results. The male to female ratio among our patients was 23:50. The mean (SD) age was 55.6 (20.2) years, and about 60% of patients were older than 60 years. The most frequent site of AL was the external genitalia (71%). In 46 cases of 67 (69%), the preceding disease was a malignant neoplasm, usually uterine carcinoma (80%).

In 44 cases, the most frequent preceding therapy was a combination of surgery and irradiation (77%), followed by surgery alone (18%) and irradiation alone (5%). The mean (SD) interval from completion of therapy to the development of AL was shorter after combination therapy (10.3 [5.8] years) than after surgery (16.5 [12.2] years) or irradiation (14.7 [11.8] years) alone. Where LND was performed, the mean (SD) interval to the appearance of AL was much shorter (3.7 [2.4] years) (Table) (P < .001).

Comment. More aggressive combination therapy can induce AL earlier than treatment with a single entity. Our study population was small, especially the number of patients treated with only irradiation, so further study in a larger population is needed. Combination therapy with both surgery (including LND) and irradiation shortens the interval to the appearance of AL. These results indicate that patients who undergo LND should receive careful follow-up for several years.

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Author Contributions: Dr Chiyomaru had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Chiyomaru. Acquisition of data: Chiyomaru. Analysis and interpretation of data: Chiyomaru and Nishigori. Drafting of the manuscript: Chiyomaru. Critical revision of the manuscript for important intellectual content: Chiyomaru and Nishigori. Statistical analysis: Chiyomaru. Study supervision: Chiyomaru and Nishigori.

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COMMENTS AND OPINIONS

“Cutaneous T-Cell Lymphoma”?: Cutaneous TNMania in Cutaneous Lymphomas

In the recent consensus statement on granulomatous mycosis fungoides and granulomatous slack skin (GSS), there was a misuse of the TNM staging terminology in Table 1. This misuse will not affect outcomes for patients with either disease, but it reflects the confusion that still abounds in the field of cutaneous lymphoma.

Nomenclature is the foundation of our specialty. Shortcuts are the bane of our specialty. I suspect that the mistake made in this article resulted from an attempt at expediency of reporting rather than a lack of the authors’ understanding of the science. Indeed, one of the many authors listed is on record as affirming that the TNM system was developed for mycosis fungoides, not for variants like follicular mucinosis or, in the case of the article in question, GSS. In Table 1, under the heading “Granulomatous Slack Skin,” the patients are listed as having their stages assigned by TNM. Granulomatous slack skin is not the disease that defined the TNM system used for mycosis fungoides.

The TNM system is often used as a shortcut to describe what the patient actually has. (For the appropriate use of the TNM system and terms, see articles by Heald and Giard and others.) Among dermatologists, the actual description is often much more lucid. For example, why not say that 10% of the body surface was involved with GSS? Among our oncology colleagues, it is not unusual to speak in TN-Mese simply because they are uncomfortable with our terms macule, papule, patch, plaque, and tumor. But among dermatologists and in a dermatology journal, precision and perfection should be our goals. We do not need to drop into this shorthand, and we should not extend it with the belief that it should apply to all cutaneous lymphomas.