COMMENTS AND OPINIONS

Neutrophilic Dermatosis of the Dorsal Hands: A Variant of Erythema Elevatum Diutinum?

We read with interest the article by DiCaudo and Connolly1 reporting 7 cases of neutrophilic dermatosis of the dorsal hands (NDDH). The authors' conclusion and the editorial by Cohen2 tend to merge this condition with Sweet syndrome (SS). We believe, however, that the reported features of NDDH better fit the diagnosis of erythema elevatum diutinum (EED) for the following reasons:

Clinically, lesions in the patients of DiCaudo and Connolly are predominantly distributed over the dorsal aspects of fingers and hands in a roughly symmetrical pattern (patients 1-7) but involve other extensor surfaces, too (patients 2 and 4). The label NDDH thus seems too restrictive in view of the topographical variations of this condition. Although not pathognomonic, these topographical variations undoubtedly resemble those of EED. Lesions in patients with NDDH include firm, reddish vesicular or pustular papules, nodules, and plaques in addition to ulcerated and vegetating lesions. In our opinion, the combination of these features favors the diagnosis of EED rather than SS. Indeed, ulcerative and vegetative lesions are not unusual in EED,3-5 in contrast to SS. Moreover, atrophy and scars reported in patients 4 and 6, which are related to the destruction of collagen fibers, are classic features of EED3-5 whereas SS is a nonscarring dermatosis. Lastly, the systemic symptoms reported in patients with NDDH are not restricted to SS and may be severe in EED, as pointed out by Katz et al.5

Histologically, vascular fibrinoid necrosis is a constant finding in the patients of DiCaudo and Connolly, and it is unlikely that this phenomenon is simply an "innocent bystander." Vasculitis, along with dense neutrophilic dermal infiltrate, is a strikingly common feature of both NDDH and EED. In contrast, the occasional presence of leukocytoclastic vasculitis in SS seems an epiphenomenon.2 Histologically consistent with SS, the back lesion of patient 2 provides a clear link between SS and the hand lesions in the authors' opinion.1 Yet, as we assume NDDH to be a variant of EED, we view this finding incidental, a possible overlap of EED and SS.

However, all things considered, is the issue of NDDH nosology of more than theoretical relevance, and is distinction between different neutrophilic dermatoses mandatory? It should be emphasized that evolution, treatment, prognosis, and spectrum of associated pathologic conditions vary according to each entity. We recently reported a pattern of IgA antineutrophil cytoplasmic antibody immunofluorescence that may further distinguish EED from other neutrophilic dermatoses.6 Differentiation should therefore be maintained, at any rate, until pathophysiological mechanisms are better elucidated. Of significance is the association of EED with monoclonal IgA gammopathy,3 which may have been undetected in the patients of DiCaudo and Connolly in the absence of serum protein immunoelectrophoresis.

In our opinion, SS and so-called NDDH represent different entities, the latter condition sharing multiple common histological and clinical characteristics with EED. We hypothesize that future observations may lead to a better delineation of NDDH but believe that there is currently no sufficient evidence to separate this entity from EED.

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