

Pulsed Dye Laser Treatment for Multiple Sebaceous Hyperplasia Secondary to Cyclosporin[☆]

Hiperplasias sebáceas múltiples secundarias a ciclosporina: tratamiento con láser de colorante pulsado

To the Editor:

Cyclosporin is an immunosuppressive drug that has been associated with several secondary skin alterations. These include hair follicle changes (hypertrichosis, keratosis pilaris, acne, and folliculitis) and gingival hyperplasia.¹ However, very few cases of eruptive multiple sebaceous hyperplasia (MSH) secondary to cyclosporin have been reported. Among the possible therapies for MSH, treatment with CO₂ ablative laser and pulsed dye laser (PDL) has been described on only a few occasions. We describe 2 cases treated with PDL, which has the advantage of offering excellent results with a better safety profile and greater patient comfort.

A 41-year-old man with skin phototype IV had started immunosuppressive therapy with cyclosporin at a dose of 140 mg/d after undergoing liver transplant. A few months later he presented with a rash consisting of dozens of yellowish umbilicated papular lesions that were clinically and histologically compatible with MSH and remained unchanged months later though the dose of cyclosporin was halved. The lesions were mainly located on the forehead, cheeks, chin, and upper back (Figure 1). He received 3 sessions of PDL treatment (Cynergy Multiplex, Cynosure, Inc., Westford, MA) with a beam diameter of 5 mm, a pulse duration of 2 ms, and a fluence of 15 J/cm². On the larger lesions 2 passes were made with a 1-minute interval between pulses. Continuous airflow cooling (Cryo5 Zimmer Medizinsysteme GmbH, Neu-Ulm, Germany) was applied at maximum level. A complete response was obtained in more than 75% of the lesions and a partial response in the rest. No crusting, blistering, or secondary pigmentary changes developed. The patient only presented minimal atrophic scarring. We found no recurrence of the treated lesions at the 6-month follow-up despite continuing treatment with cyclosporin at a dose of 75 mg/d (Figure 2).

The second case was a 41-year-old man with skin phototype II-III treated with immunosuppressive therapy using cyclosporin at a dose of 150 mg/d after kidney transplantation, who had lesions similar in appearance and distribution to those of the previous case. A diagnosis of MSH was made, and he received treatment with PDL in 2 sessions, using identical parameters to those of the previous case. The response was very good, with total disappearance of more than 75% of the lesions and no associated adverse effects. The remission persisted 4 months after treatment.

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Figure 1 Patient 1, showing facial multiple sebaceous hyperplasia secondary to maintenance immunosuppressive therapy using cyclosporin.

MSH is a benign proliferation of the sebaceous glands that in most cases is idiopathic and affects the elderly. However, it has been observed in patients treated with systemic corticosteroids, on hemodialysis, and in conditions such as Torre syndrome, X-linked hypohidrotic ectodermal dysplasia syndrome, and pachydermoperiostosis. In some cases reported in the literature, the authors suggest a possible association with cyclosporin.² Although the lesions are benign, they may have major cosmetic and psychological effects on the patients because they are located mainly in the facial region. It is therefore very important to eradicate them. The treatment options traditionally used include surgical excision, curettage, cryotherapy, cautery, and CO₂ laser, all of which are aggressive and involve a high risk of scarring and pigmentary changes. Photodynamic therapy using PDL, intense pulsed light, and red or blue light-emitting diodes has also been used recently with good results.^{2,3} The advantage of these procedures is that they avoid post-treatment purpura; the disadvantages are greater pain and higher cost, and possibly the need for a greater number of sessions to obtain results.² PDL has recently been described in the successful treatment of sebaceous hyperplasia and of other multiple and benign skin lesions, such as xanthelasma, angiofibromas, and molluscum contagiosum.⁴⁻⁶ PDL eliminates MSH quickly, easily, and painlessly (without anesthesia) and only involves a transient purpuric effect. It therefore avoids the risks of the traditional techniques described above. Most lesions disappear after a single



Figure 2 Patient 1 after treatment with pulsed dye laser. He continued with the immunosuppressive therapy.

treatment. The effect of PDL could be explained by its selective action on the telangiectatic component of the lesion, leading to destruction of the vessels that nourish the sebaceous hyperplasia. This treatment was recently described with in vivo confocal microscopy imaging before and after treatment with PDL, showing that a few minutes after application of the beam the vessels surrounding the sebaceous duct were replaced by amorphous and coagulated material.⁷

In conclusion, PDL is a fast, painless, well-tolerated, and safe therapeutic option for the treatment of MSH.

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Concomitant Dermatitis Herpetiformis and Plaque Psoriasis: Possible Skin Manifestations of Celiac disease[☆]

Coexistencia de dermatitis herpetiforme y psoriasis en placas, ¿dos manifestaciones cutáneas de la enfermedad celiaca?

To the Editor:

Immune-mediated skin diseases are triggered by a complex interaction between individual genetic susceptibility and environmental factors. Genetic and epidemiologic data from numerous sources suggest a link between diseases that appear to have little in common, such as Crohn disease, ulcerative colitis, lichen planus, dermatitis herpetiformis, and psoriasis. One possible association that has been identified is that between psoriasis and dermatitis herpetiformis. The association is supported by the fact that both diseases share genetic polymorphisms in several immunoregulatory genes, and that patients with psoriasis have a higher prevalence of celiac disease than the general population (4.34% vs 1%-2%).¹

A 50-year-old man, with mild plaque psoriasis on his elbows and knees for over 20 years but no other relevant past medical history, consulted for the progressive appearance of intensely pruritic bullous lesions around the psoriatic plaques on the extensor surfaces of his arms and

legs in the previous months. Examination revealed small, symmetrically distributed, morphologically identical blisters on an erythematous base; the blisters measured 3 to 7 mm in diameter and contained a clear fluid (Fig. 1). The patient reported no other symptoms related to other body systems. The rest of the skin examination was unremarkable. Hematoxylin-eosin staining of a biopsy specimen from 1 of the blisters showed numerous neutrophilic infiltrates in the dermal papillae and a blister at the dermoepidermal junction. Direct immunofluorescence study of healthy perilesional skin revealed granular deposits of immunoglobulin (Ig) A in the papillary dermis (Fig. 2), and biopsy of a plaque from 1 of the elbows confirmed the diagnosis of psoriasis (Fig. 3). Laboratory tests detected anti-tissue transglutaminase antibodies at a titer of over 100; the results were negative for antiendomysial and anti-gliadin antibodies. The rest of the results, including glucose-6-phosphate dehydrogenase levels, were normal or negative. The patient was diagnosed with concomitant dermatitis herpetiformis and plaque psoriasis. Biopsy of the small intestine confirmed the diagnosis of celiac disease. The patient was started on a gluten-free diet and oral sulfone at a dose of 100 mg/day. Three months later, the bullous lesions had disappeared completely and the psoriasis score, assessed using the Psoriasis Area and Severity Index, had improved from 3 to 1.

The coexistence of plaque psoriasis lesions and dermatitis herpetiformis is rare and has only been described in anecdotal reports. Numerous authors, however, believe that there is an association between psoriasis and celiac disease. It has been observed, for example, that over 16% of patients with psoriasis have IgG and IgA anti-gliadin antibodies, IgA antitransglutaminase antibodies, and IgA antiendomysial antibodies.² Other studies have demonstrated improvements in psoriatic lesions in patients who followed a

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