with a maintenance therapy of intravenous immunoglobulins every 2 months.

The characteristic cutaneous manifestations in SM, also known as generalized lichen myxedematosus,[1] is a widespread eruption of 2- to 3-mm, firm, waxy papules, often in linear arrays, and the sclerodermoid induration of the skin. These characteristic skin findings were observed concomitantly with other unusual clinical findings in this patient. Nodular eruption[3,4] and scalp involvement leading to alopecia have been reported only sporadically.[3] Interestingly, the recently reported cases, with a prominent nodular eruption, presented in absence of underlying paraproteinemia.[3,4] Associated hematologic diseases in SM include Waldenström macroglobulinemia, Hodgkin lymphoma, and non-Hodgkin lymphoma, particularly after chemotherapy with melphalan.[1] To our knowledge, immune thrombocytopenia has not been reported previously in SM. Based on the current classification,[1] a final diagnosis of atypical form was made (SM without monoclonal gammopathy). Long-term follow-up to further characterize the natural course and prognosis in these patients is required.

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Lupus erythematosus–like skin eruption after vemurafenib therapy

To the Editor: Vemurafenib (PLX4032, Zelboraf, Roche Registration Ltd, Welwyn Garden City, UK) is a selective inhibitor of the oncogenic BRAF kinase activity.[1] The BRAFV600 mutation is the most common protein kinase mutation reported in melanoma with a frequency of 40% to 50%.[2,3] BRAF is a member of the RAF kinase family, which acts in the ERK/MAP kinase pathway, a signaling cascade regulating cellular proliferation, differentiation, and survival.[3] Vemurafenib treatment of patients with metastatic melanoma carrying the BRAFV600E mutation results in partial or complete tumor regression in the majority of patients and increases overall survival time.[4,5]

Common adverse events during vemurafenib therapy include photosensitivity, fatigue, rash, and arthralgia.[4,5] Furthermore, approximately one third of the patients develop epithelial tumors of the skin such as warts, squamous cell carcinomas, and keratoacanthomas.[1,4,5]

Hereby, we wish to report a case of lupus erythematosus–like skin eruption after vemurafenib therapy in a 70-year-old woman with stage IIIc progressive metastatic melanoma (pT4bN3M0). After excision of a 8-mm thick primary tumor on the left upper aspect of her back and lymph node dissection of the left axilla (7 metastatic of 19 lymph nodes), the tumor reoccurred within 26 months. Because the melanoma cells were found to have the BRAFV600E mutation, vemurafenib therapy was started at the regular daily dosage of 1920 mg. The treatment was well tolerated for a total of 4 months but then needed to be paused for 4 months because of fatigue and nausea. Vemurafenib was reinitiated at a total dose of 960 mg daily for 2 months and then increased to 1920 mg twice daily for another 2 months. Because of gastrointestinal discomfort and flareup of a rash the treatment was aborted. The rash started with erythematous macules on the face and subsequently over the next 2 to 4 weeks progressed into demarcated, infiltrated, scaly plaques that were symmetrically distributed over all sun-exposed body areas, particularly the face, décolleté, and upper aspect of the back (Fig 1, *A*). Histopathology revealed interface dermatitis with follicular plugging and dermal mucin deposition consistent with a lupus

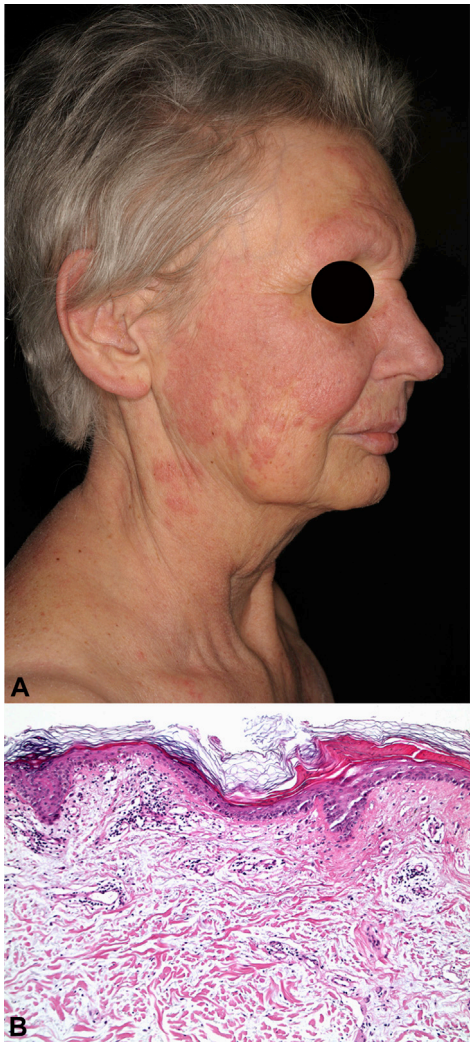

Fig 1. **A**, Sharply demarcated erythematous plaques in a 70-year-old woman developed in the context of vemurafenib melanoma therapy. **B**, Histology demonstrated interface dermatitis with follicular plugging and dermal mucin deposition consistent with lupus erythematosus–like eruption. (**B**, Hematoxylin-eosin stain; original magnification: ×20.)

erythematosus–like pattern (Fig 1, *B*). Indirect immunofluorescence showed elevated antinuclear antibody titers (1:320). Muscle creatine kinase was normal, which excluded the differential diagnosis of paraneoplastic dermatomyositis. There was no increased photosensitivity after 24 hours of ultraviolet A/B exposition. Moreover, photopatch testing also showed no sign of belated, increased photosensitivity after 4 weeks. Topical treatment of these lupus-like plaques was implemented with topical mometasone furoate cream that lead to gradual recovery within 4 weeks. In addition, the patient was instructed as to the careful use of sun blockers. Over the course of time the underlying disease progressed, with radiotherapy and chemotherapy needed.

The clinical and the histologic presentations of our patient are consistent with a lupus erythematosus–like skin eruption that was most likely associated with the vemurafenib therapy. A paraneoplastic reaction cannot totally be excluded but would be unusual in the context of malignant melanoma. Although the patient did not show increased photosensitivity we speculate that both the already well-known side effect of photosensitivity that can be an initial symptom of lupus erythematosus and the lupus erythematosus–like skin eruptions mark a spec-trum of vemurafenib-induced drug reactions. The pathomechanism behind this reaction pattern needs further investigations.

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Localized insulin-dependent amyloidosis with scar-tissue formation

To the Editor: The incidence and prevalence of diabetes mellitus has increased dramatically in the last few years as a result of increasing prevalence of