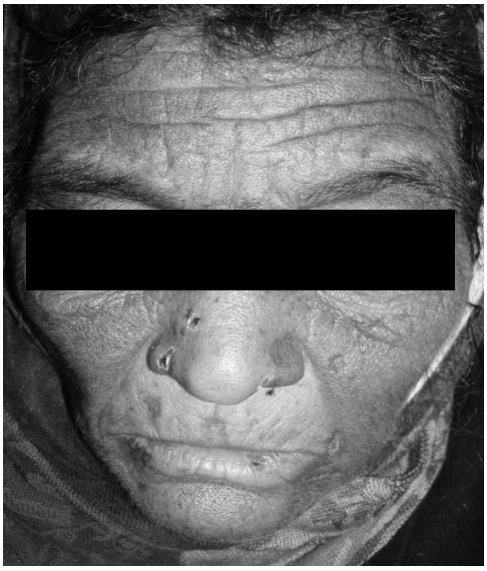
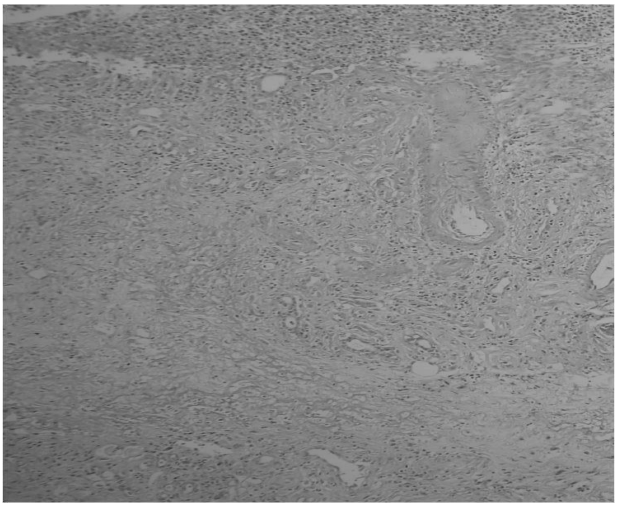
On her face, there were crusted erosions and accentuated brown pigmentation with hypertrichosis but there were no milia or sclerodermoid changes (Fig 2).

Figure 2 : Crusted erosions and accentuated brown pigmentation of the face with hypertrichosis.



There was no mucous membrane involvement and physical examination was otherwise normal. Histological examination of a cutaneous biopsy revealed an eroded and crusted epidermis with no inflammatory dermal infiltrate but a thickening of the vessel walls (Fig3).

Figure 3 : Eroded and crusted epidermis with thickening of the vessel walls and no inflammatory dermal infiltrate



Direct immunofluorescence examination of perilesional skin was negative. In front of the medical history and clinical aspects, haemodialysis-induced pseudoporphyria or porphyria cutanea tarda were suspected. The total plasma porphyrin level (erythrocyte protoporphyrin level: 0.48 nmol/L; normal<190 and erythrocyte coproporphyrin 1.82 nmol/l; normal <150), and fecal porphyrin level (126 nmol/ g; normal <200) were normal. The urine porphyrins could not be done because of anuria. The diagnosis of pseudoporphyria was then made. Strict avoidance of traumatisms and direct sun exposure with daily use of a broad-spectrum sun protection factor sunscreen failed to prevent further blistering. The patient developed frequent secondary infections of blisters and erosions needing oral antibiotics and local care with antiseptics and topical emollients.

Conclusion

Pseudoporphyria is a term used to describe patients with clinical and histological features similar to porphyria cutanea tarda but with normal porphyrin levels. This uncommon dermatosis should be suspected by clinicians, because of its relative frequency in patients with renal failure under haemodialysis. Our case illustrated the difficult management of this debilitating disorder in that skin fragility may persist even with correct sun protection.

References

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Primary Splenic lymphoma

Several tumoral processes can affect the spleen. Splenic involvement is common in both Hodgkin Disease and Non Hodgkin Lymphoma (NHL). In fact, as a filter to clear the blood, the spleen is commonly involved in hematologic malignancies. In a study by Hahn JS and Al, 20% of all lymphoma patients have had evidence of splenic involvement [1]. However, isolated or primary splenic involvement is rare. It occurs in approximately 1 to 2% of all lymphomas at presentation [2, 3]. The vast majority of wich is non hodgkin lymphoma [4]. The few number of reported cases is associated to an ambiguous definition. DasGupta defined it as disease confined to the spleen or hilar lymph nodes in which no recurrence of disease becomes evident for at least 6 months after splenectomy [5]. We describe herein the case of a 50-year-old woman who underwent successful resection of a primary lymphoma of the spleen.

Case report

A 50-year old woman was admitted with a history of left upper-quadrant pain without fever. Physical examination showed a well appearing woman with only a splenomegaly (2 cm below the left costal margin). No peripheral lymphadenopathy was