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◇Case Report

〈本文p.825～828〉

A case of severe atopic dermatitis with *Staphylococcus aureus* bacteremia

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Abstract

A 24-year-old Japanese man with severe atopic dermatitis presented with fever. A diagnosis of *Staphylococcus aureus* bacteremia was made from detecting the bacteria in 2 sets of blood culture and skin erosion. The 4-week antibiotic cured the bacteremia. The dermatitis lesion site may have served as a bacterial entry-route because *Staphylococcus aureus* isolated from the blood and skin erosion shared the same antibiotic susceptibilities. While past reports suggested that interventions to reduce *Staphylococcus aureus* in atopic dermatitis lesions did not make eczema better, further research is required to examine whether the treatment effectively decreases Staphylococcus aureus bacteremia.

〈本文p.829～832〉

A case of Costello syndrome with atopic dermatitis

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Abstract

A 21-year-old female had been diagnosed with Costello syndrome from poor weight gain, unusual facial feature, growth disorder and hypertrophic cardiomyopathy from birth. *HRAS* gene mutation was detected at the age of 11 years old. She had widespread dark brown pigmentation with lichenification and scratching on the face, neck, trunk and limbs. She had also a papilloma on the nose and curly hair. The laboratory data showed high serum IgE level of 27440 IU/m*l*. Taken together with these findings, she was diagnosed with atopic dermatitis in addition to the Costello syndrome.

〈本文p.833～836〉

A case of atopic dermatitis with infective endocarditis

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Abstract

A 42-year-old man, who was diagnosed with atopic dermatitis since he was a child, had not been treated for two years. He displayed symptoms of common cold. His condition had worsened, and he showed high fever and clouding of consciousness. *Staphylococcus genus* was detected from blood culture. Transthoracic echocardiogram revealed vegetation on the mitral valve. He was diagnosed as infective endocarditis with sepsis and DIC. He also showed erythroderma posteczematosum, which might lead to an epidermal barrier defect and bacterial invasion. In atopic dermatitis patients whose condition worsens, we should suspect the possible occurrence of infective endocarditis.

◇Case Report

〈本文p.837～840〉

Two inpatients of atopic dermatitis: the utility of tape-stripping of the stratum corneum as biomarker

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Abstract

Several proteins in tape-stripped samples of the stratum corneum have been reported recently as biomarkers for atopic dermatitis. We focused the galectin-7 and heat shock protein 27kDa, and based on serial measurements in the same patients, the galectin-7 and heat shock protein 27kDa content changed in tandem with the changes in the severity of the skin lesions. Measurement of their content in tape-stripped samples was useful for evaluation of atopic dermatitis.

〈本文p.841～844〉

A case of atopic dermatitis with intractable bronchial asthma treated with omalizumab

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Abstract

A 48-year-old woman with atopic dermatitis complicated by intractable asthma and eosinophilic granulomatosis with polyangiitis. She presented with notable pigmentation of her face, as well as mixed erythema, pigmentation, scratch marks, and lichenification on her neck and back. Total serum IgE level was ＞ 7,500 IU/mL. She was administered 600 mg of omalizumab every 2 weeks for poorly controlled asthma. Although she experienced fewer asthma attacks, there was no clear improvement in her skin eruptions or in her serum thymus and activation-regulated chemokine (TARC) levels. It is possible that the dose of omalizumab was not large enough for the high total serum IgE level present in her blood.

〈本文p.845～848〉

Conflicting clinical courses of 2 patients with severe and intractable atopic dermatitis

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Abstract

A 37-year-old man had sudden exacerbation of skin manifestations which had been stable with steroid-withdrawal therapy. The manifestations improved with oral cyclosporine. At present, he receives short-term oral cyclosporine when manifestations worsened, and he is in a state of remission. A 35-year-old man was admitted to hospital to treat sudden exacerbation. Although his manifestations were relieved, they became poorly controlled after hospital discharge. He was referred from our department to another hospital to receive steroid-withdrawal therapy.

◇Case Report

〈本文p.849～852〉

Atopic dermatitis and hand eczema

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Abstract

Atopic dermatitis and hand eczema are very common and often intercurrent diseases. A 32-year-old man and a 42-year-old man with hand eczema associated with atopic dermatitis showed eczematous lesions on the wrist and dorsal surface of the hands. This clinical feature seems to be a distinctive symptom of hand eczema associated with atopic dermatitis, because in the so-called hand eczema, eczematous lesions develop on the palmar side.

〈本文p.853～856〉

Three cases of atopic dermatitis complicated with inflammatory bowel disease

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Abstract

Inflammatory bowel disease (IBD) often has some kinds of skin lesions. Although recent epidemiological survey showed the association between IBD and atopic dermatitis, the clinical features have not been well known. Here, we focused on three IBD cases with atopic dermatitis treated in our hospital and investigated the similarity. There were no obviously common clinical findings among the cases. The timing of exacerbation of the eruption and intestinal symptoms were not parallel, therefore it was thought that the activity of IBD and atopic dermatitis has little relationship.

〈本文p.857～860〉

A case of intractable finger dermatitis due to occupational methacrylate allergy

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Abstract

A 38-year-old female continuously presented with a year history of eczema at the tips of her fingers despite of using steroid ointments. The finger pads and paronychial areas of her right hand had erythema with erosion and maceration of skin. Although she is a dental assistant, she treated denture base materials with bare hands. She was patch tested strong positive to acrylate monomer and 2-hydroxyethyl methacrylate (HEMA), and negative to bis-GMA and bisphenol A. The patch testing confirmed a diagnosis of occupational allergic contact dermatitis to methacrylate in the dental bonding material, and it improved immediately to practice no-touch technique.

◇Case Report

〈本文p.861～864〉

The follow-up of lamellar ichthyosis case revealed a severe barrier dysfunction with compound heterozygous transglutaminase 1 (*TGM1*) gene mutations

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Abstract

Lamellar ichthyosis (LI) is a form of congenital ichthyosis caused by loss-of-function mutations in the *TGM1* gene. Because the extensive cross-linking activity of keratinocyte transglutaminase 1 is crucial for the development of the epidermal barrier function, a daily moisturizing routine for dry, itchy, irritated, sensitive, and ichthyosiform skin conditions represents an important part in the life of patients with LI. An understanding of the impaired epidermal barrier function will lead to more efficient self-management and nursing care, and will also promote an improved quality of life for these patients.

〈本文p.865～868〉

Analysis of epidermal barrier function in keratitis, ichthyosis and deafness (KID) syndrome

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Abstract

A 34-year-old man with dry skin and palmoplantar hyperkeratosis. Visual impairment had started at 3 years of age and hearing loss at five. At 12 years of age, recurrent mucocutaneous candidiasis had developed. Genetic testing revealed a heterozygous c.148G>A (D50N) missense mutation, compatible with Keratitis, ichthyosis and deafness (KID) syndrome. To analysis of the patient's chronic mucocutaneous candidiasis, we performed immunohistochemical staining with antibodies against CD4, CD8, Foxp3, S100, and LL-37 (an antimicrobial peptides that play an important role in the containment of candidiasis). Based on the result of the absence of LCs, we concluded that LL-37 did not play an essential role and the induction of Th17 cells through LCs may be impaired, and that this may have contributed to his cutaneous candidiasis.

〈本文p.869～872〉

A case of self-improving collodion ichthyosis

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Abstract

We present a 1-year-old boy with autosomal recessive congenital ichthyosis (ARCI), harboring a Japanese founder mutation in TGM1 (c.919C>T, p.Arg307Trp). At birth, he presented with collodion membrane on almost whole body surface, ectropion, and fissures in the auricles, the knees and the ankles. His skin phenotype was strikingly improved within 6 months. Most collodion babies later show a phenotype of ARCI, lamellar ichthyosis or congenital ichthyosiform erythroderma. However, in about 10% of collodion babies, their skin manifestations improve spontaneously. Such phenotypes are known as "self-improving collodion ichthyosis" (SICI). So far, several reports of SICI cases caused by TGM1, ALOX12B or ALOXE3 mutations have been reported. The present case enriched the database of SICI patients harboring TGM1 mutations.

◇Case Report

〈本文p.873～876〉

A case of xeroderma pigmentosum group A

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Abstract

A 5-month-old boy was referred to our department due to a repeated history of severe erythema with blisters appearing on her face and arms when she was outdoors. Although there were no small pigmented macules on his face, xeroderma pigmentosum (XP) was suspected. Cultured cells from the patient were hypersensitive to UV, suggesting that he had defective post-UV DNA repair. The impaired DNA repair was corrected by wild type XPA expression in the patient's cells. Genetic screening revealed that the *XPA* gene was homozygous for the IVS3-1G＞C mutation, which was a Japanese founder mutation, and a diagnosis of xeroderma pigmentum group A (XP-A) was made. Since then, the patient was strictly guided to protect UV exposure to prevent skin symptoms including skin cancers. XP-A is one of the intractable diseases and the patient should be followed carefully for the evaluation and care of XP neurological abnormalities appearing in the near future.

〈本文p.877～883〉

Favorable impact of exercise with sweating on maintenance of remission of intractable atopic dermatitis: case report of three adult cases

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Abstract

Adult cases with atopic dermatitis (AD)frequently accompanied with anhidrosis, and show symptoms of skin dryness, heat retention, and susceptibility to infection. It has been reported that skin inflammation (histamine)and autonomic failure are the causative factor of anhidrosis in AD. Thus, it can be assumed that improvement of impaired sweating ability will contribute to reduce the severity of AD, and to avoid spontaneous aggravation of disease. Here, we report the 3 cases of adult AD accompanied with anhidrosis, whose symptoms were maintained in good condition by habitual exercise enough to work up a sweat. It was noteworthy that sweating exercise seemed to be useful for both the recovery of sweating ability and the maintenance of remission without intensive treatment. Our experiences indicated that search for the aggravating factors (e.g. anhidrosis)should be considered for intractable AD before initiation of intensive therapy.