# Letters to the Editor

## Eosinophilic fasciitis in a patient with psoriasis: an unusual association

Sirs,

An association of eosinophilic fasciitis (EF) with autoimmune, hematological, neurological, pulmonary and gastrointestinal tract disorders has been described. To our knowledge, the patient we describe is unique in having EF coexisting with psoriasis.

A 36-year-old man was admitted to outpatient Rheumatology clinic because of progressive stiffness in his forearms and calfs. The symptoms appeared before 5 months, after strenuous exercise. There was no history of Raynaud's phenomenon, dysphagia or respiratory symptoms. He had a 20-year medical history of psoriasis.

On physical examination, he had induration of the skin in the symptomatic areas (Fig. 1b); psoriasit rash in his elbows, knees and post auricular was noted (Fig. 1a).

Laboratory testing revealed eosinophilia (white blood cell count 6500/mm$^3$ with 17% eosinophils). C-reactive protein was elevated; creatinine kinase, transaminases and aldolase were within normal values; serum protein electrophoresis revealed diffuse hypergammaglobulinemia; Normal or negative results included antinuclear antibodies, rheumatoid factor, serum complement, Scl-70, anti-thyroid antibodies and antiphospholid antibodies.

Chest X-ray, and CT were normal. Full thickness wedge biopsy of skin, fascia, and muscle biopsy specimens were obtained (Figs 1c, 1d). The skin biopsy showed evidence of sclerodermatous changes, epidermal atrophy and collagenosis of the dermis (Masson and CAB stains, Elastica-Van Gienson and Gomori stains); moderate perivascular monocutic infiltrate, and eosinophilic infiltrate of the fascia and fibrous septa were also obtained (Fig. 1c). Sections demonstrating muscle showed thickness, collagenosis and inflammatory infiltration containing eosinophils. Histologically, this was most consistent with EF with moderate myositis. The patient was started with high dose of steroids and oral azathioprine and is under follow-up.

EF was first described by Shulman in 1974 (1). Moutsopoulos *et al*. (2) have shown the distinct histopathology of diffuse fasciitis with eosinophilia from scleroderma and morphea comparing full thickness biopsy specimens from patients with progressive systemic sclerosis, CREST, and morphea with biopsy specimens from patients with EF; in patients with EF the most striking site of involvement was the deep fascia, while none of the scleroderma, morphea and CREST patients had significant lesions in the fascia.

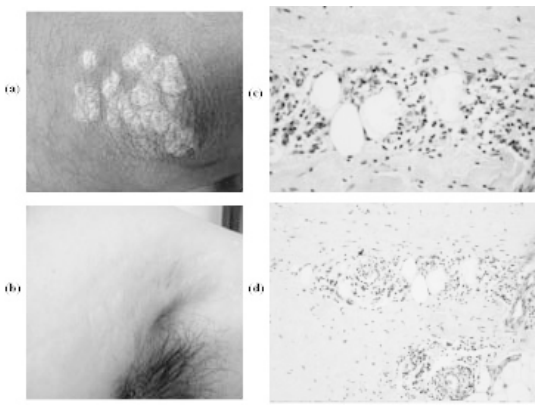

**Fig. 1.** Psoriasis in patient's elbow (a) coexisting with thickness and dimpling of the proximal extremities (b). Eosinophilic infiltrate of the fascia and fibrous septa (c). Full thickness wedge biopsy of skin and fascia biopsy specimens (d).

Extracutaneous and visceral manifestations are increasingly recognized in patients with EF. Visceral changes similar to those seen in localized and systemic scleroderma may occur in the esophagus, lung and heart. The coexistence of EF with other autoimmune diseases including active rheumatoid arthritis (3), systemic lupus erythematosus (4-6), Sjögren's syndrome (4-7), and antiphospholipid syndrome (8) is discussed in many reports. The most common type of neurological involvement observed in EF is carpal tunnel syndrome due to tenosynovitic compression of the median nerve (9). EF also has been reported in patients with multiple myeloma, myelodysplasia, hemolytic anemia, leukemia, polycythemia, Hodgkin's disease and aplastic anemia (9). Eosinophilic colitis has been reported as a part of multisystem involvement in EF patients, as well as an isolated visceral manifestation. Unusual features of eosinophilic infiltration of the lung and pleura, in addition to minor pulmonary defect has been described in many case reports. By contrast, a case of one asymptomatic woman in relation to diffuse EF has been described; the diagnosis of EF was made during her admission to hospital for an unrelated condition (10).

Our patient presented with psoriasis of his elbows, knees and post auricular along with histologically proven EF in his forearms and calfs. Although this is probably a casual association of two autoimmune conditions, its description adds another condition to the list of diseases previously coexisting with EF. Whether this association was probably due to chance because of the high prevalence of psoriasis in the general population or not, our case demonstrates the widening spectrum of EF and its possibly immune mediated pathogenesis.

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### Acknowledgements

We thank Professor Haralampos Moutsopoulos, who inspired us to report this unusual association.

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