Symmetric Erythema in A Diabetic Patient
Jung-Yi Chan  Chia-Yu Chu

CASE REPORT
A 54-year-old female patient, who has been diagnosed as having diabetes mellitus for more than 10 years without regular medical control, was transferred to our hospital due to active upper gastrointestinal (UGI) bleeding and impending hypovolemic shock. Asymptomatic skin rashes developed symmetrically on the four extremities on admission. She had been treated with ampicillin/subactam for 4 days in another hospital for symptomatic pyuria. Erysipelas or cellulitis was suspected by the internal medicine doctors. On physical examination, she was afebrile. Several well-defined, palmsized, erythematous patches distributed symmetrically on the forearms, dorsal hands, and legs with swelling were noted. There were also purpura and bulla formation on both shins (Fig. 1, 2). The peripheral pulsations were all intact.

The hemogram revealed WBC: 6300/mm³. The erythrocyte sedimentation rate (ESR) level was within normal limit. The X-ray studies of the feet and hands did not reveal any destructive bone lesions.

A skin biopsy taken from the erythematous lesion on her left forearm (Fig. 3). revealed no remarkable epidermal change with solar elastosis and sparse inflammatory cells in the dermis microscopically. Many ectatic vessels were also noted in the dermis (Fig. 4). The skin lesions were gradually resolved two weeks later without active treatments.

From the Department of Dermatology, National Taiwan University Hospital.
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Reprint requests: Jung-Yi Chan, M.D., Department of Dermatology, National Taiwan University Hospital, N0. 7, Chung-Shan South Road, Taipei 100, Taiwan, R.O.C. TEL: 886-2-23562141 FAX: 886-2-23934177

Fig. 1
Erythema, bullae and purpurual on both lower legs

Fig. 2
Closer view of the left lower leg

Fig. 3
Erysipelas-like erythema was noted on the left arm where the skin biopsy was taken

Fig. 4
Ectatic vessels were seen in the dermis (H & E stain, x40)
DIAGNOSIS: *Erysipelas-like erythema in diabetes mellitus (EEDM)*

**DISCUSSION**

Erysipelas-like erythema, one of the cutaneous manifestations due to small vessel insufficiency in diabetes mellitus was first described by Lithner.¹⁻⁴ The erythema is well-dermacated, painless with the size of a child's palm or larger and is mainly located on the legs and feet of diabetic patients.² It is not associated with pyrexia, elevated ESR, or leukocytosis. In most of the patients in the Lithner's original report, their average age was 73 and the average duration of diabetes was 5.4 years.² The erythema appeared to be precipitated by cardiac decompensation with or without leg edema, or by venous thrombosis with resulting unilateral edema.² It was obvious that swelling always preceded the development of erythema and that the latter receded when swelling subsided.² The skin lesions were usually reversible. It is characteristic that the skin lesions may recur after once having healed, may be at a site other than that at which they were first observed. It was also noted that increased percentage of roentgenologic evidence of bone destruction in involved feet of EEDM. They considered this erysipelas-like erythema to be incipient gangrene and the bony destruction to be the result of an underlying microangiopathy.³

Histopathologically, there are many ecstatic vessels in the dermis. The mechanism is attributed to the compensatory increased peripheral microcirculation caused by decreased perfusion of large vessels in diabetic complications.⁵

The most important differential diagnosis of EEDM is erysipelas or cellulitis. Lack of systemic manifestations such as fever, leukocytosis and increased ESR in addition to the symmetrical distribution of diffuse erythema and neither local heat nor pain, all suggested a diagnosis of EEDM.

**REFERENCES**