Lace bug infestations may have health consequences, including nuisance biting and cutaneous and systemic reactions. Clinicians should be aware of the existence of this insect with its newly recognized bloodsucking ability as potentially responsible for skin lesions and pruritus that can cause real discomfort and anxiety. Bites from the lace bug may also be considered in the differential diagnosis of bedbug bites and scabies.

Arezki Izri, MD, PhD  
Valérie Andriantsosanirina, PhD  
Olivier Chosidow, MD, PhD  
Rémy Durand, PharmD, PhD

**Author Affiliations:** Université Paris 13, Bobigny, France (Izri, Andriantsosanirina, Durand); Laboratoire de Parasitologie-Mycologie, Hôpital Avicenne, Assistance Publique-Hôpitaux de Paris (AP-HP), Bobigny, France (Izri, Andriantsosanirina, Durand); UMR 19Q, Unité des virus émergents, Université Aix-Marseille, Marseille, France (Izri); Université Paris-Est Créteil Val de Marne, Créteil, France (Chosidow); Service de Dermatologie, AP-HP, Hôpital Henri-Mondor, et Centre d’Investigation Clinique (CIC) 006, Créteil, France (Chosidow); Institut de Recherche pour le Développement, UMR 216, Mère et enfant face aux infections tropicales, Paris, France (Durand); PRES Sorbonne Paris Cité, Université Paris Descartes, Faculté des Sciences Pharmaceutiques et Biologiques, Paris, France (Durand).

**Corresponding Author:** Rémy Durand, PharmD, PhD, Laboratoire de Parasitologie-Mycologie, Hôpital Avicenne, AP-HP, 125 rue de Stalingrad, 93009 Bobigny CEDEX, France (remy.durand@avc.aphp.fr).

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**Nodular Amyloidosis of the Penis: A Case Demonstrating Keratinocyte Origin**

Herein we describe the first case to our knowledge of primary nodular amyloidosis of the glans penis, in which the amyloid originates from keratinocytes rather than immunoglobulins.

**Report of a Case** | A man in his 50s presented with a 6-year history of slowly expanding asymptomatic lesions on the penis that “bruised” after sexual activity and had eluded correct diagnosis for over 6 years. On examination, the patient had painless, raised, firm, translucent-to-yellowish nodules on the glans penis and distal shaft, suggestive of nodular amyloidosis (Figure 1). The biopsy revealed a mixed cellular infiltrate of lymphocytes and plasma cells as well as a few globules of amorphous hyaline-like material in the reticular dermis (Figure 2A). Congo red staining was positive, with birefringence (Figure 2B). Immunohistochemically, the amyloid was positive for 34ßE12 (Figure 2C). No specific staining for either κ or λ light chain was seen. Screen results for systemic amyloidosis with serum immunoglobulin light chains and urinary Bence-Jones proteins were negative. The clinical appearance, the histologic findings, and the absence of systemic involvement were consistent with the diagnosis of primary cutaneous nodular amyloidosis of the glans penis.

**Discussion** | Primary cutaneous nodular amyloidosis is typically characterized by single, tan or yellow, waxy nodules or plaques that preferentially occur on acral areas such as the lower extremities, head, trunk, scalp, and genitals. To our knowledge, 14 cases of primary cutaneous amyloidosis of the penis have been reported, and all were the nodular type. In contrast to keratin-derived deposits found in cutaneous macular amyloidosis and lichen amyloidosis, light chain–derived amyloid has historically been the histologic
hallmark of nodular amyloidosis. Of 14 previous cases of penile nodular amyloidosis, only 1 was tested for high-molecular-weight keratins and stained positive for cytokeratin 5. In our case, however, immunohistochemical findings were positive for 34ßE12, a monoclonal antibody against certain high-molecular-weight keratins (cytokeratins 1, 5, 10, 14) that reacts strongly with epidermal keratinocytes and also with the amyloid in macular amyloidosis and lichen amyloidosus. In addition, there was no specific immunostaining for κ or λ light chains.

Of interest are parallel findings in a case series of primary cutaneous amyloidosis of the auricular concha and external ear reported by Wenson et al. All 11 cases in that report showed strong positivity for 34ßE12, while none were positive for cytokeratins 5 or 6 or pancytokeratins AE1 or AE3. These findings suggest that the amyloid in their series was likely derived from the residuum of basal epidermal keratinocyte degeneration. Our case and theirs raise the possibility that cutaneous nodular amyloidosis may not be exclusively of immunoglobulin-light-chain origin.

Our current notion of nodular amyloidosis as immunoglobulin derived is, in fact, based on a small number of individual case reports or case series. The accumulating evidence of a keratinocyte origin for at least some cases of nodular amyloidosis suggests that its causes may be more heterogeneous than previously believed.

Management of this condition can be difficult. Previous reports describe 5 cases of penile nodular amyloidosis that were treated surgically, while 9 required no intervention because they were either asymptomatic or not associated with systemic disease. For asymptomatic nodular amyloidosis, conservative management with regular monitoring for systemic progression has been considered reasonable. For more severe cases, surgery may be appropriate.

Our findings suggest that biopsy including immunohistochemistry studies to define the nature of the amyloid deposits has merit. If the amyloid appears to arise from keratinocytes rather than immunoglobulins, there may be less need to monitor for systemic disease. This case also highlights the need for clinical vigilance to recognize this rare entity morphologically and institute appropriate investigation and management.

Whan B. Kim, BSc
Martin C. Chang, MD
James J. Limacher, MD
James C. Shaw, MD

Author Affiliations: Michael G. DeGroote School of Medicine, McMaster University, Hamilton, Ontario, Canada (Kim); Department of Pathology and Laboratory Medicine, Mount Sinai Hospital, Toronto, Ontario, Canada (Chang); Department of Laboratory Medicine and Pathology, University of Toronto, Toronto, Ontario, Canada (Chang); Division of Dermatology, Department of Medicine, University of Toronto, Toronto, Ontario, Canada (Limacher, Shaw); Women’s College Hospital, Toronto, Ontario, Canada (Shaw).


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Culinary Metaphors in Dermatology
Eating Our Words

Emily C. Milam, BA; Euphemia W. Mu, MD; Seth J. Orlow, MD, PhD

Culinary allusions are abundant in medicine, which boasts a descriptive buffet of visual signs and findings. With over 450 analogies documented in the medical literature, those pertaining to food are the most plentiful.1,2

Dermatologists especially relish culinary analogies. Food helps us describe color—as in port-wine stains, café au lait macules, and honey-colored crusts of impetigo—and texture—including cauliflower ears, peau d’orange skin, and the cheesy exudate of thrush. Gustatory aromas pervade as well, such as in the sweet grape-like scent of pseudomonal infections or the smell of stale beer in scrofula. We often use food analogies in instructing patients—for example, to apply a pea-sized amount or a grain-of-rice worth. From the breakfast, lunch, and dinner beadbug bites to the tapioca-like vesicles of dyshidrosis, every meal and food group is covered.

Dermatopathologists are in on the fun too. There are the histologic banana bodies of ochronosis or bananas on a tree in Spitz nevi. The sandwich sign is indicative of dermatophytosis, and spaghetti and meatballs on potassium hydroxide (KOH) examination of tinea versicolor. Finally, those with a sweet tooth will appreciate the bubble gum collagen in keloids and layer cake pattern in necrobiosis xanthogranuloma or necrobiosis lipoidica.

As this cornucopia of terms suggests, culinary metaphors are widespread in dermatology. Gastronomic terms are useful mnemonics for the well-seasoned practitioner and ripening trainee alike. Food analogies also help us to better connect with our patients and students, digesting complex and abstract medical concepts into bite-sized pieces, so that dermatology can become more palatable, enriched, and fresh.

Author Affiliations: The Ronald O. Perelman Department of Dermatology, New York University School of Medicine, New York.

Corresponding Author: Euphemia W. Mu, MD, The Ronald O. Perelman Department of Dermatology, New York University School of Medicine, 240 E 38th St, Floor 11, New York, NY 10016 (Euphemia.Mu@nyumc.org).


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