Meyerson Phenomenon: Description of a Case

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CLINICAL IMAGE

A 44 year old man came to our observation for a mole check. On clinical examination we noticed the presence of a series of melanocytic pigmented lesions of the trunk and upper limbs surrounded by a symmetric erythematous scaly area (Figure 1). We made a diagnosis of Meyerson phenomenon for which we did not require further investigation. Because the patient referred a severe itching, we prescribed a topical anti-inflammatory cream and recommended a follow-up visit after eight months.

In 1971, Lawrence B. Meyerson firstly described the cases of two men with benign melanocytic nevi surrounded by eczema and he considered this as an atypical form of pityriasis rosea. Subsequently, this cutaneous manifestation has been called Meyerson nevus [1,2], Meyerson phenomenon (MP) [3] and halo eczema [4]. Its pathogenesis is not well understood, even if in the literature is reported the up regulation of ICAM-1 that suggest a role for these cytokines [5]. MP is mainly found in young adults, with an equal frequency in both genders, while it is rarer in children. MP generally appears on the trunk or limbs [6], such as an area of erythema around a melanocytic lesion. It more often involves a single nevus but may affect multiple nevi. Usually, it is asymptomatic, although sometimes it can manifest with itching [7,8]. Meyerson phenomenon tends to resolve spontaneously with some months. Topical corticosteroid therapy may be given in case of intense inflammation and itching [3,8]. In some cases following inflammatory process may observe a hypo-pigmented result around melanocytic nevus that persist [1]. MP has been associated with congenital and acquired nevi, but it may be involved another types of cutaneous lesions such as seborrheic keratos, dermatofibromas, the basal and squamous cell cancers [9], keloid, insect bites [8]. The histological analysis is characterized by parakeratosis, acanthosis with an interstitial lymphocytic infiltrate in the superficial derma, sometimes with eosinophils [2-4]. The inflammatory infiltrate is mainly CD4+, while the inflammatory reaction of Sutton nevus is essentially CD8+ mediated. Also differs from allergic contact dermatitis due to the lack of cells expressing the receptor for interleukin 2. Clinically MP must be differentiated from the roseola of secondary syphilis, the pityriasis rosea, the Sutton nevus and allergic contact dermatitis [1-3]. In conclusion we can say that the MP is a rare event, to date not well clear, but that has a favorable course.

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REFERENCES


Figure 1 Series of melanocytic pigmented lesions of the trunk and upper limbs surrounded by a symmetric erythematous scaly area.

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