firmed that fibulin and fibronectin were target molecules of IgA autoantibodies.[3]

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Financial Disclosure: None reported.

1. Odom RB, James WD, Berger TG. *Andrews' Diseases of the Skin*. 9th ed. Singapore: Harcourt Asia; 2000:644.
2. García-Ortega P, Mascaro F, Corominas M, Carreras M. Blepharochalasis misdiagnosed as allergic recurrent angioedema. *Allergy*. 2003;58(11):1197-1198.
3. Schaeppi H, Emberger M, Wieland U, et al. Unilateral blepharochalasis with IgA-deposits [in German]. *Hautarzt*. 2002;53(9):613-617.
4. Sackesen C, Sekerel BE, Orhan F, Kocabas CN, Tuncer A, Adalioglu G. The etiology of different forms of urticaria in childhood. *Pediatr Dermatol*. 2004; 21(2):102-108.

Localized Contact Urticaria Caused by Lidocaine/Tetracaine Peel

The lidocaine, 7%/tetracaine, 7%, cream Pliaglis (Galderma Laboratories, Fort Worth, Texas) (hereinafter, "LT peel") is a novel topical anesthetic cream that forms a self-occlusive, pliable membrane on exposure to air. The LT peel has been shown to be a safe and effective form of local anesthesia for various dermatologic procedures.[1] Minimal adverse effects associated with the LT peel have been reported, limited primarily to transient skin erythema with or without skin discoloration or edema.[1] Herein, we report a case of contact urticaria and discuss possible causes of such allergic manifestations and potential hazards and precautions recommended with the use of the LT peel.

Report of a Case. A 26-year-old nonatopic woman developed erythema and edema of the face and angioedema of the lips 15 minutes after application of the LT peel to her entire face prior to laser treatment for acne scarring. Her medical history was insignificant. She was previously taking no medications and reported no known allergies. She reported mild pruritus, burning, and tingling of the face and was instructed to remove the medication. Slightly edematous, well-demarcated, erythematous plaques appeared, consistent with localized contact urticaria (**Figure 1**). Extracutaneous involvement was limited to mild lip swelling (**Figure 2** and **Figure 3**A). Although she reported tingling of the tongue, she did not develop systemic anaphylaxis. Treatment with a single dose of oral diphenhydramine (50 mg) resulted in gradual improvement with resolution of symptoms within 30 minutes (Figure 3B).

Comment. Studies have shown the LT peel to be well tolerated with minimal adverse reactions.[1] In cases of allergic reactions to local anesthetics, approximately 1% are secondary to IgE-mediated hypersensitivity.[2,3] Most, however, are due to nonimmunologically mediated mechanisms, which do not require prior sensitization. Such nonimmunologic causes may be attributed to anxiety, high dose, rapid absorption, or drugs capable of inducing either the same final common pathway of mast cell degranulation[2] or through unknown mechanisms related to release of vasoactive substances. Nevertheless, either mechanism can produce similar "allergic" symptoms, including urticaria, pruritus, facial edema, angioedema, bronchospasm, and potentially anaphylaxis.

Allergic reactions from the LT peel may be due to sensitivity to its anesthetic components or preservatives (parabens).[2] Ester-type local anesthetics such as tetracaine are more common causes of allergic reactions

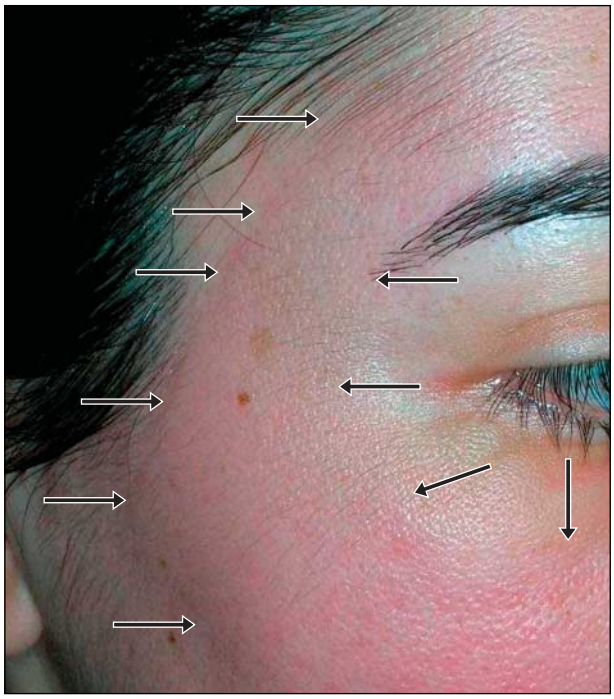

Figure 1. Slightly edematous, well-demarcated, erythematous plaque appearing 15 minutes after application of lidocaine, 7%/tetracaine, 7%, cream to the face. Arrows designate the margins of the plaque and correspond to the edges of the area where the cream was applied.

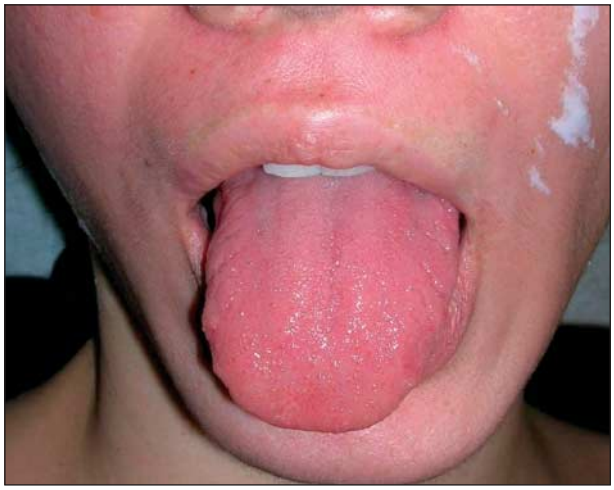

Figure 2. Well-demarcated areas of facial erythema and mild lip edema without evidence of lingual edema.

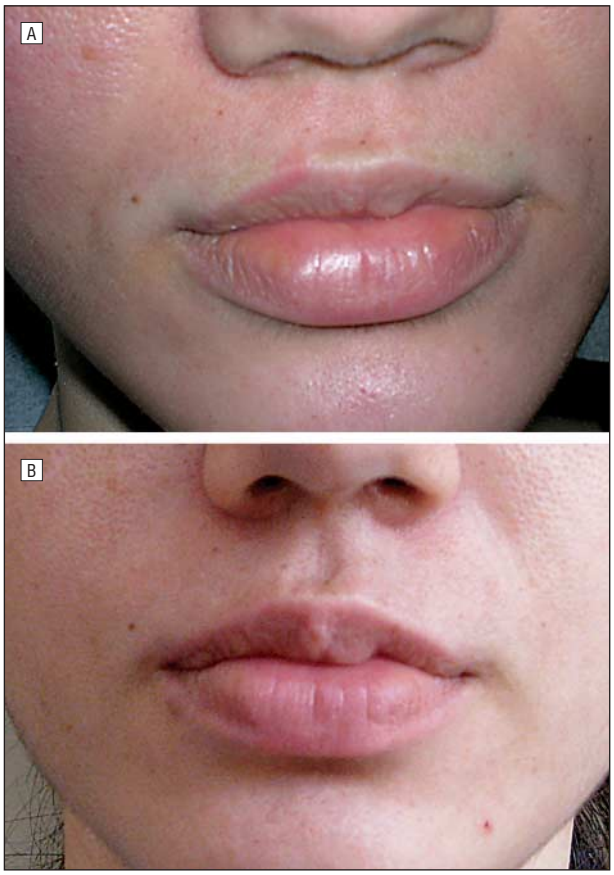

Figure 3. Mild lip edema occurred 15 minutes after lidocaine, 7%/tetracaine, 7%, cream was applied to the face (A) and resolved, as did the contact urticaria, within 30 minutes of treatment with a single 50-mg oral dose of diphenhydramine (B).

secondary to the highly immunogenic metabolite *p*-aminobenzoic acid (PABA). Parabens, commonly found in foods and cosmetics, are derivatives of PABA, and many patients who are sensitized can develop an allergic response when cross-reactivity occurs.[4] Another possible mechanism of the local erythema seen in the present case may be related to the anesthetic properties blocking sympathetic nerves and resulting in vasodilation.[4]

Although several studies have reported the LT peel to be safe, the unique self-occluding properties may potentially mask an allergic reaction because the skin is concealed. The anesthetic properties of the mask may also diminish sensation to the underlying skin. Studies have shown that systemic adverse reactions are unlikely with the LT peel owing to the small dose absorbed,[5] but dermatologists should be vigilant for possibly hidden localized reactions that might evolve into a full-blown anaphylactic reaction.

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Financial Disclosure: None reported.

1. Alster TS. The lidocaine/tetracaine peel: a novel topical anesthetic for dermatologic procedures in adult patients. *Dermatol Surg*. 2007;33(9):1073-1081.
2. Phillips JF, Yates AB, Deshazo RD. Approach to patients with suspected hypersensitivity to local anesthetics. *Am J Med Sci*. 2007;334(3):190-196.
3. Glinert RJ, Zachary CB. Local anesthetic allergy: its recognition and avoidance. *J Dermatol Surg Oncol*. 1991;17(6):491-496.
4. Boren E, Teuber SS, Naguwa SM, Gershwin ME. A critical review of local anesthetic sensitivity. *Clin Rev Allergy Immunol*. 2007;32(1):119-127.
5. Ogden L, Love G, Basta S. Systemic exposure to lidocaine and tetracaine is low after an application of a lidocaine 7%–tetracaine 7% peel in adults. *Int J Dermatol*. 2008;47(1):87-90.

Treatment of Delusional Parasitosis With Aripiprazole

Delusional parasitosis (DP) is a psychiatric condition in which patients believe they are infested with skin parasites. Since patients seeking dermatologic care are convinced that they have a skin disorder and frequently reject psychiatric care, dermatologists should be trained in managing DP. We report 2 cases that responded rapidly to the new antipsychotic agent aripiprazole.

Report of Cases. *Case 1*. A 42-year-old woman with systemic lupus erythematosus reported a 2-year history of bugs biting her scalp, axilla, and pubis. She observed lice burrowing in her skin and brought samples wrapped in tissue paper to the dermatologist. Her medication had not changed prior to the onset of symptoms. Physical examination findings were negative for nits or lice. Microscopic findings of the samples provided by the patient were negative. We reassured her by saying that we would analyze samples and perform some tests if she accepted admission to our unit. Blood and urine tests and chest radiography revealed no abnormalities. She was diagnosed with primary DP, and aripiprazole treatment was started at 5 mg/d, with an increase to 10 mg/d 2 weeks later. In a 1-month follow-up visit, she explicitly said that parasites no longer troubled her. Six months later, she was in complete remission. No adverse effects were detected, and the treatment was withdrawn. After 6 months without therapy, the patient did not relapse.

Case 2. A 49-year-old man with human immunodeficiency virus presented with a 3-year history of generalized excoriations. He complained about parasites biting his skin, which made him scratch to take them out. He showed us digital photographs and movies of his parasites. The patient did not change his medication during the months before the onset of symptoms. Burrows were not observed in the physical examination. He was admitted to our institution where an organic cause for DP (including drug abuse) was ruled out. Aripiprazole treatment was started at 5 mg/d, with an increase to 15 mg/d over 2 weeks. At that time, the patient did not think that he was infested by parasites and stopped scratching. One month later, he still remained in remission. The patient was then lost to follow-up.

Comment. Patients with DP characteristically bring samples of their "parasites" that are in fact small parts of