

condition masquerading as Epidermolysis Bullosa Acquisita histologically. This ultimately led to a delay in diagnosis and treatment.

Conclusions: In patients with undifferentiated bullous/erosive skin conditions occurring in photo-distributed regions, Porphyria cutanea tarda should be considered in the differential diagnosis irrespective of histopathological findings on biopsies and further investigated and treated appropriately.

Multifocal panniculitis due to *Mycobacterium ulcerans*: an unusual presentation of an increasingly common disease

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The incidence of *Mycobacterium ulcerans* in Australia is increasing at an alarming rate. It has now been detected on both sides of Port Phillip Harbour in Victoria – from the Bellarine Peninsula to Mornington.¹ It classically presents as single, or multiple, ulcerated nodules on the limbs, which are characteristically undermined.^{2,3}

We present an atypical case of *M. ulcerans*, in which an elderly female developed multifocal abscesses and panniculitis. The patient was known to be a frequent holiday-maker in Point Lonsdale, Victoria. An initial erythematous subcutaneous swelling of the right buttock was diagnosed as an insect bite reaction and debrided surgically. No tissue was sent for culture. A clinical diagnosis of an infective panniculitis was made on the basis of multiple subcutaneous nodules and abscesses on the abdomen, upper and lower limbs. Histology confirmed a mixed lobular and septal panniculitis with vasculitis and numerous acid fast bacilli seen on Zheil-Neelsen and Wade Fite stains. PCR confirmed *M. ulcerans*, and systemic rifampicin and clarithromycin were commenced.

Atypical mycobacteria have been identified as the causative pathogens in a handful of cases of infective panniculitis reported in the literature.^{4,5} Epidemiological risk factors and possible immunosuppression may have led to this unusual presentation *M. ulcerans*. This case contributes to our understanding of the breadth of presentations of a common mycobacterial infection in Australia.

References

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Advancement in calciphylaxis management: report of 3 cases

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Classically, calciphylaxis (calcific uraemic arteriopathy – CUA) has been considered a disease of patients with advanced or end-stage renal disease. However, calciphylaxis in patients without an incriminating history or renal function is not as rare as previously believed; thus patients may present to dermatology after referral from primary care.

Calciphylaxis involves life-threatening calcification of arterioles leading to necrotic infarcts of the skin and subcutaneous tissue (panniculus adiposus), erythema and livedo reticularis, followed by painful, pre-ulcerative, subcutaneous plaques with surrounding pruritic areas. These areas ulcerate revealing regions of necrotic subcutaneous adipose tissue covered by eschars with high potential for infectious complication.

The incidence of calciphylaxis is approximately 4.1% in patients on dialysis, with the reported incidence increasing over the past decade. It is associated with significant morbidity and mortality, with limited studies suggesting a one-year cause-specific mortality of 54.2%.

The rapid progression of calciphylaxis lesions highlights the need for swift response when the early signs we describe appear. It is our experience that quicker diagnosis and increasing familiarity and expertise has simplified and improved the course of recovery for these patients. Optimally, calciphylaxis is prevented. Therefore, the diagnostician must maintain a high degree of suspicion for patients with the risk factors we describe. Ongoing research and accumulating experience will be needed to improve outcomes of this devastating condition.