Case report

Asymptomatic diffuse fasciitis with eosinophilia

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SUMMARY The case of a 70-year-old woman with asymptomatic diffuse fasciitis with eosinophilia, confirmed by biopsy, is presented.

A new syndrome with skin lesions resembling those of scleroderma was first described by Shulman in 1974.¹ Termed diffuse fasciitis with eosinophilia (DFE), it is characterised by an abrupt onset and usually follows exceptional exertion. A short prodromal stage with muscle aches, low-grade fever, and fatigue commonly precedes the skin changes. The course of the eosinophilic fasciitis is then characterised by thickening of the subcutaneous tissues and pitting oedema of the arms and legs and to a lesser degree of the trunk. Other findings are peripheral blood eosinophilia and raised gamma-globulins, mainly due to increased IgG. The pathognomonic findings is a nonspecific inflammatory reaction and thickening of the fascia.

In this brief communication we present a patient who was entirely asymptomatic in relation to DFE. The diagnosis of her condition was made during her admission to hospital for an unrelated condition.

Case report

A 70-year-old housewife was admitted to hospital with a 3-day history of right upper quadrant colicky abdominal pain. Similar attacks of pain had occurred several times over the previous 9 months. Her symptoms had been attributed to cholecystitis. The past medical history was remarkable only for multiple operations performed to correct ventral hernias. No history of Raynaud's phenomenon could be elicited.

On examination she was afebrile. Thickness and dimpling of the skin of the proximal limbs and anterior trunk surface were noted. The medial aspects of the arms and anterior surface of the thighs were more extensively involved (Fig. 1). The skin was not tightly bound down and could be moved freely.

Laboratory investigations showed a haematocrit of

40% and a total white blood cell count of $9 \times 10^9/l$. The total eosinophil count was $0.9 \times 10^9/l$. A repeat eosinophil count showed $1.2 \times 10^9/l$. Erythrocyte sedimentation rate was 30 mm/hour. Other investigations, including thyroid function tests, serum protein electrophoresis, LE cells, rheumatoid factor, anti-nuclear antibodies, and antibodies to DNA, were within normal limits. A skin-to-muscle through-and-through biopsy showed normal epidermis and

Fig. 1 Thickness and dimpling of the skin of the proximal extremities and trunk.

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Fig. 1 Thickened fascia infiltrated by lymphocytes and plasma cells. (Haematoxylin and eosin, $\times 100$).

dermis. The fascia, however, was noted to be thickened with heavy round-cell infiltration (Fig. 2). Eosinophils were inconspicuous in the biopsy specimen.

Discussion

DFE has unique clinicopathological features. This has been emphasised in a recent article,² where its histology was reported to be distinct from that of scleroderma and morphoea.

Over the last 8 years more than 30 cases have been described. Associations with aplastic anaemia and thyroid disease, and some overlap with other connective tissue diseases, have been presented.³⁻⁶ None of these associated conditions or predisposing drugs⁷ could be traced in our case. The patient was entirely asymptomatic. If she had not been admitted to hospital for an unrelated condition, her fasciitis might have remained undiagnosed. It appears that her illness was

benign, of long duration, and of insidious onset in contrast to many of the cases previously reported.

References

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