Cryoglobulinemic leukocytoclastic vasculitis secondary to multiple myeloma

A 75-year-old woman was presented with necrotizing lesions on extremities (Figure 1). Skin biopsy revealed leukocytoclastic vasculitis; there was serum cryoglobulinemia (Figure 2) and IgG monoclonal peak on protein electrophoresis; bone marrow aspirate (BMA) showed no plasmacytosis, but 2.1% of clonal plasma cells in immunophenotyping. There were no osteolytic lesions. HIV, B and C hepatitis, Epstein-Barr Virus, Cytomegalovirus and syphilis serologies, anti-nuclear antibody, rheumatoid factor, antineutrophil cytoplasmic and antiphospholipid antibodies were negative; normal C3. Despite dexamethasone and thalidomide treatment, IgG level rose; stabilization was achieved with prednisone and melphalan. Four years later, she appeared with the same skin lesions and an acute

Figure 1. Extensive, erythematous, not itching but painful cutaneous plates in legs and hands, associated with infected ulcers.

Figure 2. Blood sample contained cryoglobulins—it precipitated at 4°C (upper test tube).

Figure 3. Computed tomography evidenced an osteolytic tumor on a left rib.
pulmonary embolism. Contrasted computed tomography evidenced osteolytic tumor on a left rib (Figure 3), biopsy of which demonstrated a plasmacytoma (96% of clonal plasma cells with positivity for cluster of differentiation (CD)-38, CD138, CD56 and κ-light chain). Some plasma cells revealed crystals of cryoglobulins (Figure 4). BMA evidenced 50% of clonal plasma cells and skull X-ray had lytic lesions; β2-microglobulin level was 5.823 mg/l.

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Figure 4. On optical microscopy, a specimen of the osteolytic rib tumor revealed a plasmacytoma, and some plasma cells contained cryoglobulins crystals.