ABSTRACTS FROM CURRENT LITERATURE

Administration of DAB 389 IL -2 in patients with recalcitrant psoriasis. A double blind-phase II multicenter trial. Bagel J, Garland WT, Breneman D, et al. J am Acad Dermatol 1998;38:938-944.

Current therapies for recalcitrant psoriasis focus on immunoregulation and targeting of activated T-lymphocytes rather than keratinocytes. Previous studies with low doses of the lymphocyte-selective fusion protein DAB 389 II - 2 have shown benefit to patients with psoriasis and this prompted the authors to conduct a multicenter placebo controlled trial. Forty-one patients were randomized to receive either placebo (saline infusion) or 5,10, or 15 mg/Kg daily of DAB 389 IL -2 intravenously for 3 consecutive days each week for four consecutive weeks with a subsequent four week observation period. Of the placebo group 17% exhibited at least 50% improvement from baseline Psoriasis Area and Severity Index scores at the end of the study. Whereas 24% of all treated patients showed the same improvement. The rate of improvement for treated patients was significantly greater than for placebo patients. Among treated patients, decrease in PASI scores parallelled by changes in the Physician's global Assessment and the Dermatology Life Quality Index. Treatment in ten patients was discontinued because of adverse events which included flu-like symptoms, hypotension, facial oedema and one serious adverse event involving vasospasm and thrombosis. Unlike therapy with cyclosporin, FK 506 or CD_4 monoclonal antibody treatment, DAB_{389} IL-2 does not produce paresthesias, immunosuppression or hypertension.

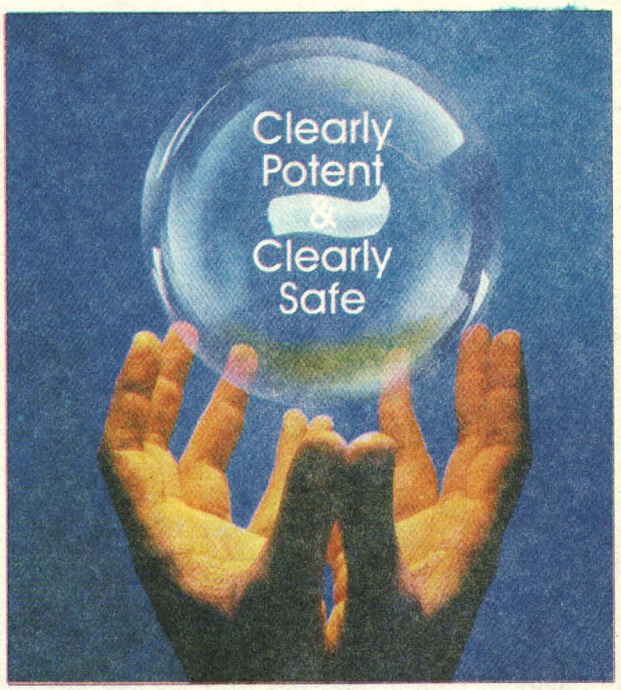
K. Jyothy

Nail splinting by flexible tube- A new noninvasive treatment for ingrown toe nails. Schulte KW, Neumann NJ, Ruzicka T J Am Acad Dermatol 1998; 39: 629-630.

Many treatments have been described for ingrown toe nails such as nail edge separation, partial matrix phenolization and the classic wedge excision. These treatment modalities may lead to severe damage of the nail fold or to frequent relapses. Therefore the authors developed a new noninvasive therapy based on the technique of Wallace, Mine, and Andrew without producing severe nail matrix damage. With the patient under local anaesthesia the lateral edge of the nail plate including the spicule is splinted with a lengthwise - incised small flexible plastic tube. The plastic tube is then attached with wound closure strips. The splinted spicule grows out without injuring the nail fold and the granulation tissue subsides. In addition the patient must be advised about proper nail trimming. This technique is simple and easy to perform and after splinting, the patient experiences instant relief of pain. Moreover with the splint in place, the patients are immediately able to resume walking in their usual shoes.

K. Jyothy

In Atopic Dermatitis#, Eczema#



A New Generation Topical Steroid[1]

Flutivate*

Fluticasone propionate 0.05% w/w
Cream

Fluticasone propionate 0.005% w/w
Ointment

- Designed to achieve Efficacy & Safety[2]
- Treatment of choice in moderate to severe dermatoses#[3]

Glaxo Pharmaceuticals *The World Leaders in Dermatology*

Abriged Prescribing Information :
Composition :
Flutivate Cream : Each 5gm contains
Fluticasone propinate 0.05% w/w
in a non- greasy base.
Flutivate Ointment : Each 5gm contains
Fluticasone propionate 0.005% w/w in a greasy base.
Indication :
FLUTIVATE* is indicated for the treatment of eczema; dermatitis, psoriasis and linchen planus.
Dosage and Administration :
Apply a tin film of FLUTIVATE* cream to affected areas, for eczema/ dermatitis once daily, and for all other indications, twice daily.
Contra-Indications:
Rosacea, Acne vulgaris, Perioral dermatitis, Primary cutaneous viral infections (eg. herpes simplex, chickenpox). Hypersensitivity to any of the ingredients. Perianal and genital pruritus, Primary infected bacterial or fugal skin lesions and dermatoses in children, under one year of age, including dermatitis and napkin eruptions.
Precautions and Warning :
Keep out of Reach of children. Overt suppersion of the HPA-axis (morning plasma cortisol< 5mcg/dl) is very unlikely to result from therapeutic use of FLUTIVATE* unless treating more than 50% of an adult's body surface and applying more than 20g per day. The other areas of the body, may exhibit atrophic changes after prolonged treatment with potent topical corticosteroids. If applied to the eyelids, care is needed to ensure that the preparation does not enter the eye so as to avoid the risk of local irritation or glaucoma.
Pregnancy and Lactation :
Administration of fluticasone propionate during pregnancy should only be considered if the expected benefit to the mother is greater than any possible risky to the foetus. However, plasma levels in patients following dermal application of fluticasone propionate at recommended doses are likely to below. The excretion of fluticasone into humen breast milk has not been investigated.
Adverse Reactions:
FLUTIVATE* is genarally well tolerated. Prolonged and intensive treatment may cause local effects such as skin atrophy, hypertrichosis and pigmentary changes, or systemic effects of hypercorticism. Systemic effects are more likely in infants and children, or where occlusion occurs, such as under the napkin:
Pharamaceutical Precautions and Recommendations:
Storage:
Store in cool place below 30°c.
Presentation : 10gm tube in a carton.

Reference
1. CHUAC, Munn S.,Fluticasone Propionate in the treatment of inflammatory dermatoses, BJCP, 1995, Vol. 49 No. 3: 131-133.
2. Goodman & Gilman's, 1996,pg. 1475.
3. Lennart Juhlin, Feb. 1996, cutis (2S), Vol. 57 no.25, 43-48.
* Trademak of Galxo Group Limited.
# Steroid Responsive Dermatoses

For full prescribing information, Please write to:
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Subacute cutaneous lupus erythematosus versus systemic lupus erythematosus. Diagnostic criteria and therapeutic implications. Chlebus E, Wolska H, Blaszczyk, et al. J Am Acad Dermatol 1998 ; 38 : 405 - 412.

The nosologic position of subacute cutaneous lupus erythematosus (SCLE) is controversial. More than 4 American Rheumatism Association (ARA) criteria for systemic lupus erythematosus (SLE) are found in a proportion of patients diagnosed as having SCLE. The purpose of this study was to determine whether ARA criteria for SLE are helpful in differentiating SCLE from SLE and whether cutaneous and visceral changes,immunologic findings and photosensitivity provide a basis for diagnosis of SCLE. A cohort of 143 SCLE, 58 with SLE, and 6 with overlapping features of both were studied clinically, histologically and immunologically and by photo-testing. The patients were observed upto 10 years. In both SCLE and SLE the majority of patients were females. The mean age of onset in SCLE was 43 years and in SLE was 32 years. Annular or papulosquamous lesions were present in all patients with SCLE but did not appear in SLE. Malar eruption and Raynaud's phenomenon were more frequent in SLE. Discoid lesions, alopecia and neurological abnormalities were found with equal frequency arthralgia, serositis or kidney disease. Anti - Ro (SS-A) and anti -La (SS-B) antibodies were found with comparable frequency in patients with SCLE and SLE. Whereas antibodies to anti-ds DNA, anti sm, and anti-u1 RNP were significantly more frequent in patients with SLE. A positive lupus band test was found in 61% of patients with SCLE versus 87% of those with SLE. Photoreproduction of lesions was observed in only 20% of SLE patients. The course of SCLE was usually milder and the prognosis was better than in SLE. Majority of the SCLE patients were controlled with small doses of corticosteroids with chloroquin, whereas those with SLE required higher doses of corticosteroids and a proportion of patients with SLE required immunosuppressive drugs also. Six cases were of overlap type with characteristics of both subsets- cutaneous involvement of SCLE and immunologic findings of SLE; most began as SLE, but later developed signs of co-existing SCLE. Thus the authors opine that patients with SCLE (although the majority fulfill more than 4 ARA criteria for SLE) show significant differences from those with SLE in terms of cutaneous and visceral involvement, immunologic findings, photosensitivity, course of the disease, and therapy requirement. Therefore SCLE should be recognised as a separate subset.

V. Bindu

Latex, a cause of allergic contact eczema in users of natural rubber gloves. Wilkinson S M, Burd R. J Am Acad Dermatol 1998;39: 36-42.

Latex is 30-40% aqueous suspension of natural rubber and is obtained by tapping rubber trees (Flevea brasiliensis). It is produced in response to wounding and its function is to form a seal over the wound by coagulation and it contains proteins. During the processing and subsequent manufacture of rubber products, many chemicals are added as preservatives, vulcanizing agents and accelerators. These additives are known to be sensitisers and it is believed that contact allergic eczema to rubber is caused by these additives and not by the natural rubber latex.

Consecutive patients attending the contact dermatitis clinic with a history of hand eczema were screened for a history of natural rubber glove use. Patients were patch tested to a standard and rubber additive series together with latex and a sample of domestic glove and vinyl glove. Test series included N-1sopropyI -N- phenyl phenylenediamine 0.1% carbamix 3% and cyclohexyl

thiophthalimide, 1%, all in petrolatum.

Patch testing was performed by means of Finn chambers secured with scanpor tape, left on the back, and reading taken at days 2 and 4.

Of 117 patients with hand dermatitis, 34 patients exhibited positive patch test results to rubber related antigens. Most common positive readings were obtained with the thiuram - mix and the carbamix. Seven patients (6%) had a positive patch test to the latex sample,5 of these patients had no other positive reaction to other allergens. Two of these patients reacted to a sample of rubber glove, 8 patients had positive reaction to cyclohexyl - thiophthalimide, and in 2 it was the only positive reaction.

The authors recommend including latex and cyclohexyl thiophthalimide in the patch test series for rubber glove related hand eczeme.

A. B. Sapna

Non pigmenting solitary fixed drug eruption caused by pseudoephedrine hydrochloride. Hindioglu U, Sahin S. J Am Acad Dermatol 1998; 38 : 499 -500.

A ten-year-old boy presented with an oedematous erythematous 7x3.5 mm plaque on the right groin which appeared suddenly 2 days back. He had an upper respiratory tract infection a few days ago and had taken triprolidine hydrochloride 60 mg . The lesion cleared completely without any treatment within 2 weeks , leaving no residual pigmentation. Then an oral challenge test was conducted, and an identical eruption at the same site developed 4 hours after administration of pseudoephedrine hydrochloride 30 mg. This again resolved within 2 weeks and the patient was instructed to avoid all pseudoephedrine containing medications.

The cause for the non pigmentation is that the changes are mainly dermal. Although oral provocation is the most reliable means of confirming the suspected cause of a fixed drug eruption, topical open provocation on post lesional skin, presents an alternative for patients who refuse oral challenge.

Other cutaneous reactions caused by pseudoephedrine are severe generalised eruption accompanied by joint swellings, recurrent pseudo scarlatina with distal desquamation, recurrent toxic shock syndrome and systemic contact dermatitis. Shelley and Shelley defined non pigmenting fixed drug eruption as a separate entity and emphasized its symmetric distribution. But in this case it presented as a solitary plaque, just like the pigmenting epidermal type.

A. B. Sapna