Response from the author

Sir,

I thank Dr. S. Panda for taking interest in our article and sharing the results of his own study (yet unpublished). It is true that the report of Kano et al,[1] who treated 3 patients with a low dose of pentoxifylline (300 mg daily), stimulated us to carry out a trial in a larger patient group to assess whether an economically viable and safe drug like pentoxifylline (Pf) would provide a therapeutic option for Schamberg's disease (SD) which, till date, remains a condition that is easy to diagnose but difficult to treat. Our preliminary results were gratifying. Now responding to Dr Panda's comments and queries:

1. Dr. Panda's statement that the topical steroids are the traditional therapeutic modality in this disorder' is far from true. Topical steroids may be of some help, particularly in itching purpura, but prolonged use may only exacerbate the problem.[2]

2. Dr. Panda agrees that capillary stasis and gravity are contributory factors in the pathogenesis of SD.[3,4] So there has been no paradigm shift as proposed by Dr. Panda after the study of Kano et al. For astute clinicians, SD always was and remains a capillaritis treated not by taking refuge in the panacea of topical steroids (as proposed by Dr. Panda). In fact, modalities like PUVA, azathioprine, griseofulvin and cyclosporin A have been successfully used in the recent past.

3. Regarding the methodology, it is clear from the title itself that we have conducted a preliminary therapeutic trial and not a case-control randomized study or a dose comparison study. So the question of using a placebo group does not arise. The purpose of conducting a pilot study is to test the efficacy of a drug in a limited number of patients and to stimulate the interest of other workers in the field. Indeed this is exactly what Panda et al have done. In fact, their own results (whatever vignettes are available from Dr. Panda's correspondence as his study is yet to be published and so unavailable for detailed review) seem to echo our methodology and results and serve as an endorsement for the efficacy of Pf. Their treatment period is also 8 weeks but surprisingly they have concluded that a 2 month period was deemed inadequate. Indeed this aspect of Dr. Panda's study disappoints me. He had the luxury of a large study group (n = 112), which was not the case with us. So what prevented him from conducting a proper dose ranging study with a placebo group instead of a comparative trial with a single dosage regimen of 1200 mg and comparing it with an outdated modality like topical steroids. Why did he limit his treatment period to 8 weeks instead of carrying on from where other preliminary trials (including ours) have ended and extended the period to 6 months. Then perhaps many of the queries he has raised would have been answered. I may further remind Dr Panda that till date our trial remains the largest published trial (n = 20) of Pf in SD. We will reserve our comments on his study for later when it is published.

4. The optimum dose of Pf in SD remains open to debate. SD is a capillaritis and not a true vasculitis. So blindly aping the conventional dose used in vasculitides (400 mg thrice daily) may not be wise. The classic example of D-penicillamine is fresh in our mind where conventionally a dose of 250 mg thrice daily was accepted in systemic sclerosis till a dose ranging study found a lower dose of 125 mg on alternate days to be equally effective.[5] Who knows we may be in for another pleasant surprise in the case of Pf in SD. Our recommendation is to conduct a dose ranging placebo controlled trial. If Dr. Panda et al, with the luxury of a study population of 112 patients, had done so, they would have provided answers to all the queries that they are raising.

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Treatment of pemphigus

Sir,

It was interesting to read the article by Balachandran.[1] I wish to point out certain discrepancies.

1. There are only 25 references mentioned in the reference section while 26 are quoted in the text. The references in the text should have been 6 to 25 instead of 7 to 26.

2. After successful treatment of Reiter's disease with dexamethasone pulse,[2] we started using dexamethasone-cyclophosphamide pulse (DCP) therapy for treating pemphigus since 1982[3] and not since1992 as quoted. Subsequently many more reports were published in different journal.[4-6]

3. The transfusion duration is 1-1.5 hours instead of 3-4 hours. The second phase of therapy is now modified to 9 pulses in place of 6. Similarly the third phase is of 9 months in place of 1 year.

4. Among the side effects quoted, viz. infection leading to septicaemia, I wish to clarify that infection does not lead to septicemia if appropriate antibiotic therapy is instituted prior to or even during the pulse therapy.

5. Most of the reports by Indian workers published in our journal have not been reviewed.

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Response by the author

I appreciate the keen interest shown by Dr. Ramji Gupta in our article 'Treatment of pemphigus'.

1. I agree that there are only 25 references. Reference number 4 in the text should be 3, reference number 5 should be 4 and so on. I regret this error.

2. Regarding the second question, I have not made any such comment in the text.

   I would like to mention that the current dexamethasone-cyclophosphamide pulse regimen is not final and needs modifications. There are now various centers in India using it, but there is no uniformity. With our vast experience in pulse therapy, we should evolve a modified uniform regimen.

3. It is better to give a slow infusion for 3-4 hours, as there is a risk of cardiac toxicity with rapid steroid infusion.

4. We have been following this regimen for many years now. We have had two deaths due to septicemia in phase 1 in spite of the patient being on antibiotics. Hence, infection is an important complication that should be appropriately treated.