LETTERS TO THE EDITOR

PENICILLAMINE INDUCED CHEILOSIS

Approximately 60% of patients with Wilson's disease and cystinuria have been reported to develop skin rashes when treated with d-penicillamine A number of other manifestations like vesicles, bullae, cysts, milia, elastosis perforans serpiginosa and pemphigus foliaceus have also been described. Cheilosis is seen uncommonly. We observed an eitht-year-old boy having Wilson's disease manifesting as difficulty in speech, difficulty in walking and in using the left upper limb, dysarthric speech, Kayser-Fleischer rings in both eyes, weakness in the proximal group of muscles, poor hand grip, rigido-spasticity on the left side, involuntary athetoid movements, and enlarged liver. Investigations showed erythrocyte sedimentation rate to be 45 mm. Serum was fairly opalescent. Caeruloplasmin level in serum was 1.7 mg%. Serum copper level was measured to be 221 micrograms per 100 ml. Zinc turbidity test showed 12.6 units. Patient's mother refused bone marrow studies. Rest of the investigations were within normal limits. A diagnosis of Wilson's disease was made and the patient treated with oral d-penicillamine in a dosage of 250 mg three times a day. On the eighth day of treatment, the patient developed cheilosis and was referred to us. A diagnosis of penicillamine drug reaction was made and the drug withdrawn until the cheilosis subsided. It was again started in small, gradually increasing doses and maintained thereafter without any recurrence of cheilosis.

Penicillamine induced skin eruptions can be of two types, viz, (1) eruptions of early onset, and (2) eruptions of late onset. Early onset eruptions appear within two weeks of starting the treatment and clear when the drug is withdrawn temporarily and usually do not reappear when the drug is restarted. The late onset eruptions are characterised by appearance of the rash after a year or more with high dose of the drug. The lesions improve if the dose is reduced. Some workers have reported cheilosis as an uncommon manifestation following penicillamine therapy.

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ROLE OF ZINC IN ERYTHEMA MULTIFORME

I have gone through the article entitled "Oral zinc in recurrent erythema multiforme with depigmentation" published in the Ind J Dermatol Venereol and Leprol, 1984; 50 : 10-12. I wish to make the following observations :

(1) The authors have studied cases with a preceding history of herpes simplex, while erythema multiforme in each case appeared later. The primary disease, therefore, was herpes simplex. Hence the title could preferably have been something like "Oral zinc in recurrent herpes simplex with recurrent post-herpetic erythema multiforme and resultant depigmentation", specifying the main disease.

(2) The authors have combined the history of all the three cases which looks odd with similar type of history and clinical features. No reference to upper respiratory infection has