LETTERS TO THE EDITOR

SINGLE DOSE ITRACONAZOLE THERAPY IN TINEA VERSICOLOR; A DOUBLE BLIND, RANDOMISED PLACEBO CONTROLLED STUDY

To the Editor,

There are numerous agents available for the treatment of Tinea versicolor (TV) with variable efficacy and which require lengthy treatment periods.[1] Fluconazole and itraconazole are the new oral triazole derivatives which are an improvement over the short comings of other existing drugs.[2]

Various short course regimens are available to treat TV. However, an ideal treatment regimen would be a low dose of the drug given for a very short period.[3] Itraconazole has been used successfully in TV in regime of 100 mg daily for 15 days or 200 mg daily for 5 days.[3] Fluconazole is effective even with a single dose of 400mg.[4] In this regard we conducted a randomised, double blind placebo controlled study with a single dose of 400mgs of itraconazole. Twenty-five patients of Tinea versicolor who were KOH smear positive and who had more than 10% of body involvement were recruited in the study. Twelve of them received 4 capsules of itraconazole of 100mgs each as a single dose and the other 13 patients received 4 similarly looking placebo capsules. All the samples were coded and labelled randomly from A...to Z by a pharmacist. The patients were assessed every 2 weeks clinically and by KOH smear up to a total of 8 weeks. The clinical assessment included grading of hypo/hyper pigmentation, scaling and itching on a severity scale of 0 to 3.

When the decoding was done, it was found that out of 13 patients treated with itraconazole, 2 patients improved clinically and mycologically by 8 weeks, and same number of patients improved in the placebo group. None of the patients in either group had any side effects.

Though the minimum inhibitory concentration of itraconazole invitro is 0.1 ug/ml[5] and the drug persists in the skin for more than 3 to 4 weeks after cessation of therapy,[6] it is clear from this study that a single high dose of 400mg of itraconazole is ineffective in the treatment of TV and this finding supports the existing view that a minimum total dose of 1000 mgs of itraconazole given for at least 5 days is necessary to treat Tinea versicolor.[3]

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References

1. Hay RJ. Treatment of superficial fungal infections. Clin Exp Dermatol 1981; 6: 509-513.

2. Cutsem VJ, Gerven VF, Janssen PAJ. The antifungal activity of azoles : in vitro and in vivo activity. 9th Congress of the National Society for Human and Animal Mycology. Atlanta, Ga:May 19-24, 1985: 3-23.

3. Delescluse J. Itraconazole in tinea versicolor: a review. J Am Acad Dermatol 1990; 23: 551-554.

4. Faergemann J. Treatment of pityriasis versicolor with a single dose of fluconazole. Acta Derm Venereol (Stockh) 1992; 72: 74-75.

5. Cutsen VJ, Gerven VF, Janessen PAJ. The in vitro and in vivo antifungal

activity of itraconazole. In: Fromtling RA, ed. Recent Trends in the Discovery, Development and Evaluation of Antifungal Agents. JR Prous Science Publishers SA, 1987: 177-192.

6. Cauwenbergh G, Degreef H, Heykants J, et al. Pharmacokinetic profile of orally administered itraconazole in human skin. J Am Acad Dermatol 1988; 18: 263-268.

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PEYRONIES DISEASE, SCLERODERMA AND DIABETES MELLITUS

To the Editor

A 55-year-old man, known case of diabetes mellitus with hypertension presented with features of scleroderma (scleroderma, Raynaud's phenomenon and difficulty in swallowing) of 3 months duration. He also complained of impotence and increased curvature of penis on erection for the past 2 months.

Skin biopsy findings were consistent with scleroderma, ANA was negative and ultrasonography revealed hyperechoeic area in the upper third of penis suggestive of Peyronies disease. Prevalence of diabetes mellitus is reported higher in patients with Peyronies disease[1] and association with systemic sclerosis has also been documented in recent literature.[2,3] Etiology of Peyronies disease remains a mystery, and recent studies on HLA antigens and immunological features suggest the hypothesis of an autoimmune etiology for the disorders.[4,5] Peyronies disease co-existing with scleroderma and diabetes mellitus in the present case corroborates autoimmune basis of the disease.

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References

1. Culha M, Alici B, Acar O, et al. The relationship between diabetes mellitus, impotence and veno occlusive dysfunction in Peyronies disease patients. Urol Int 1988; 60:101-104.

2. Ordi J, Selva A, Fonollosa V, et al. Peyronies disease in systemic sclerosis. Ann Rheun Dis 1990; 49: 134-135.

3. Gualdieri L, Valentil G, Lupoli S, et al. Peyronies disease in systemic sclerosis. Report of two cases. J Rheumatol 1988; 15: 380-381.

4. Rompel R, Mueller - Eckhardt G, Shroeder - Printzen I, et al. HLA antigens in Peyronies disease. Uro Int 1994; 52: 34-37.

5. Schiavino D, Sasso F, Nucera E, et al. Immunological findings in Peyronies disease. Urology 1997;50:764-768.

NEVUS DEPIGMENTOSUS WITH SEGMENTAL VITILIGO

To the Editor

Nevus depigmentosus (ND) is a rare, congenital, non-familial stable quasidermatomal leucoderma. Vitiligo is a common acquired heritable melanocytopenic disorder with a high incidence of associated disorders.[1]

A 13-year-old girl presented with two hypopigmented lesions. The first on the left lower back was an asymptomatic 5x4 cm macule with irregular borders, present since birth, static in size. The second lesion appeared 7 months ago in the right pectoral region extending from the anterior axillary fold to the lower part of the breast. The lesion was asymptomatic, 20x12 cm depigmented macule with trichrome appearance,