ABSTRACTS FROM CURRENT LITERATURE

Treatment of recurrent penile condylomata acuminata with external application and intraurethral instillation of Bacillus Calmette-Guerin. Bohle A, Doehn C, Kausch J, et al. J Urol 1998; 160: 394-396.

Condylomata acuminata are caused by human papilloma virus infection. Despite numerous treatment modalities including interferons, autologous vaccines and oral isotretinoin, these patients often demonstrate recurrent disease. The authors report initial experience with bacillus Calmette-Guerin therapy in patients not responding to standard treatment. Between October 1994 and March 1997, 6 men with a mean age of 27 years with rapidly recurrent external and intraurethral condylomata acuminata underwent BCG therapy after initial treatment with laser at least 3 weeks preceding the first BCG instillation. The BCG solution was prepared by dissolving 81 mg connaught strain in 2ml sterile saline and was either instilled into the urethra at low pressure or was put on a dressing which was gently wrapped around the affected areas and kept in situ for 2 hours. The procedure was repeated six times at weekly intervals. Of the 6 patients, 3 patients completed one course of BCG and had no relapse of condylomata acuminata during the follow up period of 11, 29 and 24 months respectively. Of the 2 patients who underwent a second course of BCG after a recurrence, one remained without relapse for 8 months and one had a single relapse which was laser coagulated and had no further relapses during 12 months of follow up. In the last patient, relapse occurred after BCG therapy was discontinued due to development of penile oedema and fever following the third BCG instillation. Except for mild dysuria in another patient, no other side effects were reported. Before BCG therapy, 36 condylomata acuminata recurrences were noted in 136 observation months compared to 6 episodes in 96 months after BCG therapy. Therefore the annual recurrence rate was significantly reduced from 3.2 with standard therapy to 0.75 with BCG therapy. It was found that BCG tharapy for transitional cell carcinoma of the urethra and bladder induced granulomas with predominance of CD_4+T lymphocytes and increased urinary cytokines like IL-1, IL-2 and TNF-alpha. The cytotoxic immune response against malignant and virally transformed cells appear similar and furthermore, the evidence of increased CD4 lymphocytes in regressing wart stroma and surface epithelium suggested that BCG therapy might also be successful in the adjuvant treatment of recurrent condylomata acuminata. Despite these findings, the exact mechanism of action of BCG therapy has not been elucidated. However, the results of this study of BCG therapy apparently reducing the recurrence rate in patients with condylomata acuminata are encouraging and should be tried in a larger series of patients.

Deepa B

Chronic bullous disease of childhood: successful treatment with dicloxacillin, Siegfried EC, Sirawan S. J Am Acad Dermatol 1998; 39: 797-800.

This is a case report of two patients with chronic bullous disease of childhood (CBDC) which were successfully treated with dicloxacillin.

A $5^1/_2$-year-old girl with features of CBDC was

given a two week course of acyclovir and 'cefprozil with a diagnosis of impetiginised chicken pox which was later confirmed as CBDC and given prednislone 2mg/kg daily. Her condition worsened during the next two days and dapsone 25mg/day was added. The dose of dapsone was increased to 62.5g/m day but there was no improvement. Then dicloxacillin 250mg, four times a day was added. Within a week the symptoms subsided and after two months dapsone could be withdrawn and dicloxacillin was continued for one year.

The next case was a 9-year-old girl with CBDC who was on short courses of prednisolone but had frequent relapses. Her follow up with long term treatment with prednisolone, dapsone and sulfapyridin was continued for one year.

The next case was a 9-year-old girl with CBDC who was on short courses of prednisolone but had frequent relapses. Her follow up with long term treatment with prednisolone, dapsone and sulfapyridine was not successful. Six months after the development of disease, dicloxacillin (500mg/BD) was started and she got relief from symptoms. After two years treatment, cessation of dicloxacillin produced relaps of symptoms.

Mechanism of action of dicloxacilline in CBDC is not known. Dicloxacillin has a better safety profile than other reported modes of treatment for CBDC.

Sasi J

Disease association in polymorphous light eruption - A long follow-up study of 94 patients. Hasan T, Ranki A, Jansen TC, et al. Arch Dermatol 1998; 134:1081-1085.

Polymorphous light eruption is the most common photodermatitis affecting about 20% of the Scandinavian population. The authors performed a long follow-up study of 94 patients, 23 years after their original study in 1978-79 and an average of 32 years after the first polymorphous light eruption (PLE) symptoms. The aim was to study the course of the disease and to evaluate associated conditions especially lupus erythematosus and other autoimmune diseases occurring during the period. It was a questionnaire-based follow up study complemented by clinical examination and laboratory investigations. Of the 94 patients, 22 were considered cured, 48 patients reported alleviation of symptoms and the remaining 23 patients had noticed equal or stronger symptoms than before. However, the recovery from PLE did not depend on the original clinical subtype and the age of the patients. Women reported shorter yearly duration of PLE rash and noticed PLE lesions more quickly than men and the sex of the patient did not affect significantly any other clinical characteristics of PLE. At least one autoimmune disease was diagnosed at some point in 14 patients (15%) inclusive of 13 female patients (18%) and lupus erythematous specifically in 2 of the female patients (3%), while the prevalence of lupus erythematosus in the female population of Finland was estimated to be only 0.2%. Although there is a seemingly higher incidence of lupus erythematosus in PLE patients, PLE could not be shown to be a risk factor for lupus erythematosus as the development of 2 isolated cases may have occurred by mere chance. Of the 94 patients 12 patients,, who were all females, developed thyroid disease., 4 of autoimmune origin and 8 of unknown etiology. The prevalence of hyperthyroidism or hypothyroidism, observed in 9 female patients (ie 10% of all the patients and 13% of the female patients) is also higher than the estimated prevalence in Finland, not exceeding 5%. Thus, the prevalence of any autoimmune disease in the study group was as high as 15% and even higher (22%) if hypothyroidism and non-toxic goiter was considered as autoimmune processes and still higher (28%) in the females of the study group. This is significantly more than the estimated 5-7% prevalence of autoimmune disease in the general population of Finland and 4-11% prevalence in the female population of Finland. Thus the

authors have found that PLE is a persistant disease that tends to ameliorate slowly and the female patients with PLE showed an increased risk for the development of disease of autoimmune origin or thyroid disorder, but the risk for lupus erythematosus is not increased.

Deepa B

Partial albinism with immunodeficiency : Griscelli syndrome : Report of a case and reviw of the literature, Mancini AJ, Chan LS, Paller AS, et al. J Am Acad Dermatol 1998;38:295-300.

Griscelli syndrome was first described in 1978. It is an autosomal recessive dosorder occurring in infancy and childhood. This case presented to the dermatologist at 6 weeks of age with pancytopenia, neonatal jaundice, hepatosplenomegaly and silvery grey hair. Hair microscopy showed large unevenly distributed melanin aggregates in the medulla. Electron microscopy of skin showed numerous mature melanosomes in melanocytes and few melanosomes in keratinocytes. Peripheral smear did not show giant granules. These findings help to distinguish this from Chediak-Higashi and Elejalde syndrome.

In Chediak-Higashi syndrome, hair microscopy shows evenly distributed small melanin aggregates. Skin electron microscopy shows giant melanosomes in melanocytes and keratinocytes. Peripheral smear shows giant granules. In Elejadde syndrome, unevenly distributed clumpy melanin aggregates are seen in the medulla of hair and irregular melanisation of melanosomes in melanocytes. PAS +ve granules are seen in histiocytes.

The prognosis of Griscelli syndrome is poor. Neurological defects can occur. Accelerated phases are common. This patient was treated with intrathecal methotrexate, methyl prednisolone, and blood transfusions. She developed neurological defects at 15 weeks of age.

Prenatal diagnosis of Griscelli syndrome is possible at 21 weeks by fetal scalp skin biopsy. A genetic locus has been identified at 15q 21.

Anoop UC

Pustular psoriasiform eruption with leukocytosis associated with terbinafine. Papa CA, Miller OF. J Am Acad Dermatol 1998;39:115-117.

A case of pustular psoriasiform eruption with leukocytosis associated with terbinafine is reported in a 60 year. old man treated with terbinafine 250 mg/day for culture positive *Trichophyton rubrum* onychomycosis. Seven days after initiation of therapy, erythema appeared on his lower extremities and rapidly progressed to generalised bright, erythematous, symmetrical papules and plaques studded with flaccid pustules. Face, mouth, palms, soles and nails were spared. There was no personal or family history of psoriasis. Laboratpry studies one week later revealed leukocytosis. Biopsy demonstrated spongiform pustules containing neutrophils in the epidermis and a primarily perivascular and interstitial infiltrate composed of lymphocytes, histiocytes and eosinophils. Prednisolone therapy and topical triamcinolone were started. One month after onset, skin was clear and laboratory data were within normal limits. The clinical differential diagnosis included pustular psoriasis and pustular drug reaction. Clinical history and biopsy favoured pustular psoriasiform drug eruption.

Smitha Prabhu S

Intratumoral chemotherapy with fluorouracil/ epinephrine injectable gel. A nonsurgical treatment of cutaneous squamous cell carcinoma. Kraus S, Miller B H, Swin Swinchart JM, et al. J Am Acad Dermatol 1998; 38:438-442.

Local chemotherapy with intratumoral fluro-uracil epinephrine (5Fu/epi) injectable gel was evaluated as a non-surgical approach for treating primary squamous

cell carcinoma (SCC) of the skin. This is an alternative treatment to surgery desirable for patients who prefer non surgical treatment or who are not good surgical candidates. The study enrolled twenty-five patients, all of whom had hostologically proven squamous cell carcinoma on sun exposed skin of the face, head, neck, trunk, arms or hands. A single tumour was selected for treatment in each patient which had to be a well defined accessible lesion 0.6 to 3cm in diameter with tumor confined to upper half of reticular dermis without nodal involvement or metastasis. Intra oral, lip, leg, finger, and peri ocular lesions were excluded. 5 Fu (30mg/ml) was the active drug with epinephrine (0.1mg/ml) as adjuvant for vasoconstriction in an aqueous gel system with purified bovine collagen used as biodegradable carrier matrix. Dose was 1ml of 5Fu/epi gel per lesion per week injected intradermally under the tumor and a surrounding margin of 0.5 cm. Patients received upto six treatments at weekly intervals. Sixteen weeks after completion of therapy, the lesion site was completely excised and sent for histopathological examination. Out of the 25 patients enrolled, 23 completed the study of which 22 (96%) had histologically confirmed complete tumor clearance. There was no significant systemic reactions, and local cutaneous reactions like superficial erosions and necrosis cleared after stopping treatment. Intratumoral injection of 5 Fu permits precise placement of the drug and the gel system maintains high local concentration of 5 Fu throughout the lesion. Both the gel and epinephrine contribute to enhanced 5 Fu retention, efficacy and safety. This is a non surgical, tissue-sparing modality with excellent cosmetic results and without systemic toxicity. However, no inferences can be drawn as to the effectiveness of this therapy in large, poorly defined and recurrent SCC or SCC with metastasis. To assess further the clinical utility of 5 Fu/epinephrine gel. long term follow up without excision and controlled clinical trials are required.

Bindu V