ABSTRACTS FROM CURRENT LITERATURE

Oesophageal lichen planus, Sheehan-Dare RA, Cotteril JA and Simmons AV : Brit J Dermatol, 1986; 115 : 729-730.

A 50-year-old woman with extensive erosive lichen planus of the tongue, lips, gums and buccal mucosa developed painful dysphagia located at the level of the upper sternum. Fiber-optic endoscopy revealed erosive changes in the oesophagus extending to 25 cm from the incisors. There were areas of desquamation, the separated mucosa hanging off in sheets. Contact bleeding was readily induced. Biopsies from the affected upper oesophagus revealed non-specific inflammatory changes with basal cell hyperplasia and lymphocytic infiltration.

A diagnosis of oesophageal lichen planus was made and treatment was started with oral prednisolone 20 mg/day plus cimetidine 400 mg twice a day. She had rapid symptomatic improvement, but repeated attempts to withdraw corticosteroids resulted in recurrence of dysphagia. In the symptom free period, endoscopic examination revealed absence of inflammatory changes in oesophagus. Oesophageal involvement with erosive lichen planus is rare but diagnosis is important. Differentiation from peptic oesophagitis is important since corticosteroids which are effective in oesophageal LP are contraindicated in peptic oesophagitis.

K Pavithran

Localized subepidermal bullae after intravenous phenobarbital, Haroun M, Jakubovic HR and Nethercott JR : Cutis, 1987; 39 : 233-234.

The occurrence of bullous lesions in patients with barbiturate-induced coma is well known. Here the authors report an 83-year-old man with advanced cancer of prostate who developed multiple blisters at the site of intravenous injection of phenobarbital. The bullae ranged from 0.2 to 6.5 cm in diameter and some were surrounded by an erythematous margin. The bullae showly resolved over the next two weeks. Histopathological study of an early vesicle revealed a subepidermal bulla with the basement membrane retained on the dermal surface. There was no necrosis of the epithelium of sweat glands or their ducts.

This eruption may be due to extravasation of phenobarbital solution, which has a pH of 9.3. Authors suggest that this reaction may be more specific; bullae continued to appear for two days after the intravenous infusion was discontinued and extended for some distance beyond the local site of extravasation of the drug. Although phenobarbital is not a commonly used intravenous medication, physician should be aware of this potential adverse effect.

K Pavithran

Pityriasis rosea and the need for a serologic test for syphilis, Horn T and Kazakis A : Cutis, 1987; 39 : 81-82.

Syphilis, especially in its secondary stage, is a great mimicker and it is well known that pityriasis rosea-like eruption may sometimes be a manifestation of secondary syphilis. So many physicians order a serologic test for syphilis in all patients in whom the diagnosis of pityriasis rosea is considered. Here, the authors undertook a study to determine the frequency with which secondary syphilis presented as pityriasis rosea.

Fifty consecutive patients with pityriasis rosea were evaluated and RPR titer measured

at the initial visit. It was non-reactive in 47 patients. Two patients had titers 1 : 2 and 1 : 2 but gave history of treatment for syphilis in the past. Another patient developed the eruption 4 weeks after treatment for primary syphilis. His RPR titer was 1 : 16. He had a herald patch and the titer continued to decrease and eruption cleared without further treatment. Authors conclude that a proper history and clinical examination are important in differentiating pityriasis rosea from syphilis. Absence of constitutional symptoms, lymphadenopathy and mucosal lesions enable to diagnose pityriasis rosea.

K Pavithran

Para-tertiary-butylphenol formaldehyde resin part 1 : Leather watch straps and shoes, Fisher AA : Cutis, 1987; 39 : 183-184.

Para-tertiary-butylphenol formaldehyde (PTBF) resin is being increasingly used in leather articles such as leather watch straps and shoes to laminate various fabrics and leather linings to the outer, thicker leather. Here, authors report two cases of contact allergic dermatitis to PTBF. A 46-year-old woman developed a dermatitis of the wrist from a new leather watch strap. Results of patch tests were strongly positive to leather shavings from the strap and 1% PTBF in petrolatum. Later, it was learnt that the glue or cement used to apply the inner lining of the strap to the outer leather band contained PTBF resin. Another old man developed dermatitis of feet 2 sweek after wearing a new pair of shoes. Results of patch tests to the shoe-tray, including potassium dichromate and rubber chemicals, were negative except for a strongly positive patch test reaction to PTBF resin 1% in petrolatum. Author concludes that all patients with dermatitis of the wrists or dorsal aspect of the feet should be tested with PTBF resin.

K Pavithran

Peri-anal Bowen's disease associated with ano-rectal warts : a case report, Fiumara NJ and Wagner RF : Sex Trans Dis, 1987; 14 : 58-60.

The authors report a 55-year-old homosexual man with an ano-genital wart who has been followed up intermittently over a period of 26 years. He finally developed two granulomatous nodules morphologically different from the lesions of condyloma acuminata. Histopathological study of the nodules revealed features of Bowen's disease. Although the aetiology of Bowen's disease is still unknown, three predisposing factors have been associated with this disease : (1) solar radiation, (2) ingestion of inorganic arsenicals, and (3) infection with the papilloma virus.

The nodules were surgically excised. The warts were treated with podophyllin and they resolved rapidly after three weekly visits.

The aetiologic agent for condyloma acuminata, the human papilloma virus (HPV), has been classified by DNA hybridization techniques into at least 42 types, of which types 16 and 18 are considered to carry a high risk for cancer. Authors conclude that failure of the warts to respond to treatment or changes in their appearance warrants a biopsy, and where facilities are available, typing of the DNA of the virus should be carried out.

K Pavithran

Painful red leg nodules and syphilis : a consideration in patients with erythema nodosum-like illness, Silber TJ, Kastrinakis M and Taube O : Sex Trans Dis, 1987; 14 : 52-53.

Many types of skin lesions are known to occur in syphilis. The authors report a 15-year-old girl who presented with painful and tender nodules of both lower legs. A clinical diagnosis of erythema nodosum was made and she was investigated to detect any underlying cause. Usual laboratory tests performed in cases of

erythema nodosum were either negative or within normal limits. Because she was sexually active, the patient was also routinely screened for sexually transmitted diseases. A rapid plasma reagin test was found to be strongly positive. The FTA test also was positive. A diagnosis of syphilis was made and on treatment with inj benzathine penicillin 2.4 mega units, the nodules underwent regression over the next two to three weeks. The mechanism of the development of an erythema nodosum-like illness in syphilis is unknown. Some are of the view that it is a specific reaction whereas others consider this as a non-specific allergic reaction. Authors state that whenever patients present with erythema nodosum, a screening test for syphilis should be performed.

K Pavithran

Urethral trichomoniasis in men, Lalit AS, Mason PR and Marowa E : Sex Trans Dis, 1987; 14 : 9-11.

Authors studied 5873 patients suffering from non-gonococcal urethritis. Of these 325 (5%) had urethral trichomoniasis. Their mean age was 30.4 years whereas patients with non-trichomonal urethritis had the mean age 26.1 years. Symptoms were present for more than four weeks in most of the patients with urethral trichomoniasis whereas in patients with non-trichomonal urethritis the duration of presenting symptoms was less than two weeks. Milky-white fluid discharge of trichomoniasis showed clumps on smear examination and on Gram staining showed numerous epithelial cells and a few pus cells. Three hundred and thirteen patients showed *Trichomonas vaginalis* in wet preparations of urethral discharge and in the remaining 12, *Trichomonas vaginalis* were found only in the urinary deposits. Along with this study, authors studied 218 subjects with confirmed gonococcal urethritis for concomitant *Trichomonas vaginalis* infection. Only 1.4% showed concomitant infection. All patients with trichomoniasis gave 100% cure rate with 400 mg of metronidazole thrice daily for five days.

K Sobhanakumari

Gonorrhoea and the story of resistant *Neisseria gonorrhoeae*, **Sehgal VN and Srivastava G : Internat J Dermatol, 1987; 26 : 206-209.**

Now-a-days gonorrhoea and disseminated gonorrhoea are increasing because of the emergence of penicillin and other antibiotic resistant *Neisseria gonorrhoeae*. Penicillin resistance is due to the production of penicillinase which was first noticed in late 1975. Some organisms show decreased susceptibility to penicillin and other antibiotics due to chromosomal mutation. Penicillinase converts penicillin into its inactive form penicillinoic acid. Penicillinase production is mediated by the resistance factor R plasmid. In Gram positive organisms, penicillinase is an extracellular enzyme whereas in Gram negative organisms it is an intracellular enzyme. PPNG strains are divided into Asian and African strains depending upon the molecular weight of the plasmid and the nutritional requirement of gonococci. Asian strains have got a conjugate plasmid also. PPNG strains have been demonstrated in more than forty countries now. PPNG have the same spectrum of clinical manifestations as *Neisseria gonorrhoeae* per se. When the disease fails to respond to the usual line of treatment, suspect the presence of resistant strain and see whether penicillinase is present by doing chromogenic cephalosporin test or acidometric test or rapid iodometric test. Spectinomycin, newer preparations of cephalosporine, aminoglycosides, rifampicin and augmentin are the treatment for these PPNG strains.

K Sobhanakumari

Recent trends in the chemotherapy of paucibacillary leprosy, Katoch K : (adapted from CJIL Quarterly Bulletin, 6 (1) 1987)ICMR Bulletin, 1987; 17 : 51-54.

With the introduction of newer potent drugs, chemotherapy of leprosy has completely changed and the multidrug therapy is now very popular in both paucibacillary and multibacillary cases. The WHO recommended schedule for paucibacillary cases consists of dapsone 100 mg daily (unsupervised) and rifampicin 600 mg once a month (supervised) and the whole treatment is stopped at the end of 6 months even if the lesions show clinical activity. Cases of relapse in such cases have been reported.

Here the author at Central Jalma Institute for Leprosy, assessed 3 regimens containing rifampicin. Regimen I was same as that recommended by WHO for paucibacillary cases and was stopped at the end of 6 months. Regimen II was similar to regimen I but was continued for one year and then stopped. Regimen III consisted of rifampicin 600 mg daily for 7 days in the first month and subsequently 600 mg once a month for 5 more months. Dapsone 100 mg daily was administered for one year and then stopped. In the first part of the study, patients were evaluated after 6 months of therapy in all 3 groups. The inactivity indices were 0.70, 0.66 and 0.64 respectively. At the end of one year the inactivity indices were 0.76, 0.94 and 0.97 respectively. The bacteriological and clinical deterioration seen in 18 of the 25 active patients on regimen I was not encountered in any patients on regimens II or III. 18 required subsequent therapy and in others lesions regressed spontaneously. The initial intensive therapy for 7 days with rifampicin did not offer any advantage. This study very clearly showed that irrespective of the number of patches, type of disease, and lepromin status, the patients of paucibacillary leprosy respond equally effectively if treatment is continued for one year.

K Pavithran