LETTERS TO THE EDITOR

EFFECT OF PARENTERAL VITAMIN D3 IN SKIN DISEASES

To the Editor

Taking the clue from the topical use of vitamin D3 derivatives in psoriasis and its efficacy, we in AIMS, B.G. Nagar, tried vitamin D3 parenterally in psoriasis. For the experimentation we used Arachitol of Duphor company, 3 lakhs international units intramuscularly every week for 4 weeks and we found substantial improvement in 4 patients. In first week itself, there was decrease of erythema and scaling. By the end of 4 weeks erythema disappeared, the plaque thickness diminished by 80%, no new lesions appeared and some lesions disappeared altogether. What is of interest is that all four patients had extensive psoriasis, involving around 40% of skin surface and not few plaques.

Extending this interesting observation further, we tried the same dose in 2 cases of lichen planus. After 2 weeks, the lesions regressed by 50%. Some lesions disappeared and new ones did not appear. Both the patients had complete relief from itching.

We tried the same regimen in 4 cases of photodermatitis. After 4 weeks the lesions in all disappeared leaving residual pigmentation. All had complete freedom from itching.

The conclusion therefore is that vitamin D3, parenterally has got antipruritic, anti-inflammatory and healing properties, on skin. It is also evident that vitamin D3 administered intramuscularly could be a good adjuvant to existing dermatological therapies.

The only theoretical objection for using vitamin D3, parenterally, could be hypercalcemia. However even after repeated checking in these patients serum clcium levels did not cross 11 mg%.

We are reporting this observation, because we feel that parenteral vitamin D3 may prove an important medicine or an adjuvant in the treatment of many skin conditions.

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HAND DERMATITIS IN BEAUTICIANS

To the Editor

This is with reference to the article entitled "Hand dermatitis in beauticians" published recently.[1] We wish to share our experience in this regard.

Our study comprised of 16 female beauticians in and around Manipal with working experience ranging from 4 months to 20 years. A detailed history of atopy, contactants, symptoms, aggravating factors and protective measures used was taken. All except 7 used gloves for hair dyeing and perming. These 7 (43%) noted burning sensation and peeling of skin over finger tips after contact with perming lotion and burning sensation alone with bleaching cream which subsided within a few days. There was history of atopy in 3 out of which one had past history of itching with vesicles following use of hair dye without gloves. Two others complained of itching and burning alone after use of hair dye. Nine (56%) had dryness of skin. Other findings noted were promi-

nent skin markings over fingers, rough skin, orangish discolouration of finger pulps and nails following use of henna. Two had warts and callosities. However none had active hand dermatitis on examination. Hence patch tests were not done.

We feel that hand dermatitis is not a common problem in our beauticians due to their awareness and use of protective measures. In our study only one had past history of itching with vesicles in the absence of protection. Dryness of skin can be attributed to frequent washing of hands with soap and water. Perming lotions, hair dyes and bleaching creams contain irritant substances which can cause contact dermatitis. Use of gloves when handling these agents is imperative.

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Reference

1. Neena Khanna. Hand dermatitis in beauticians in India, Indian J Dermatol Venereol Leprol 1997;157-161.

MUPIROCIN IN FOLLICULITIS CRURIS PUSTULOSA ET ATROPHICANS

To The Editor,

Chronic folliculitis of the legs is known to dermatologists since many years and was referred to by different names including folliculitis decalvans, epilating folliculitis of glabrous skin etc.[1] This chronic folliculitis has been consistently shown to be due to *Staphylococcus aureus*. Different modalities including antiseptics, dyes,[1] tincture iodine,[2] cotrimo - xazole, dapsone and PUVA therapy[3] have been used with varying results. Mupirocin is a new topical antibiotic reported to be as effective as systemic antibiotics, especially against *Staphylococcus aureus*.[4] Hence we tried topical mupirocin 2% ointment in the management of these patients.

Three patients with chronic folliculitis were treated. All three of them were young adults in the group of 20-30 years. Two of them had the disease for 3-4 years and the third patient had it for a long duration of 10 years. One was a gardener by occupation, second was a peon in an office and third patient was a manual labourer. None of them was involved in cutting sugarcane or fishing, the occupation which have been implicated as etiological factors.[5]

Patients were advised to use topical mupirocin ointment twice daily after washing and were followed at weekly intervals. Response was impressive with 50% improvement in 7 days and complete clearing in 4 weeks. The first patient had no recurrence over 6 months follow up, whereas other patients have just completed the treatment one month back and are on follow-up.

Mupirocin, is an antibiotic with a unique mode of action. It acts as a competitive inhibitor of the enzyme isoleucyl transfer RNA synthetase and competes with the amino acid isoleucine for binding sites and thus inhibits protein synthesis. Its MIC against *Staphylococcus aureus* is 0.25 mcg/ml and it has a very low sensitizing potential and is devoid of serious side effects. Because of the unique mode of action, it is unlikely to lead to cross resistance with other systemically used antibiotics. In our