Kerosene-induced acute irritant dermatitis

To the Editor:

Kerosene is a widely used refined petroleum product. As true for all petroleum distillates, it is a known irritant. Frequently it is blamed for causing chronic irritant dermatitis[1]. However an acute irritant reaction to kerosene, as reported below, is a rare manifestation.

A 24-year-old male patient was referred to us from emergency outdoor. Examination revealed intense vesiculation and erythema over the lower abdomen, anterior thighs and genitalia. History of recent spilling of kerosene (12 hours earlier) over the affected area with intense burning sensation corroborated the clinical diagnosis of acute irritant dermatitis. Dramatic response was seen with ciprofloxacin 500 mg twice daily, cetirizine 10 mg daily and local clobetasol propionate gentamicin cream given for 10 days. Healing occurred with residual hyperpigmentation. Thereafter standard patch test with kerosene was negative.

Irritant dermatitis is caused by direct action of irritant through nonimmunologic mechanisms. Kerosene, by virtue of its fat dissolving property causes such reaction. However, rarity of acute irritant reaction with kerosene is not in accordance with its wide usage. Persons with atopic dermatitis have been shown to have increased susceptibility to develop chronic irritant dermatitis.[2] It is possible that similar factors play a critical role in development of acute irritant dermatitis with chemicals having low irritancy potential like kerosene. It may be equally possible to get such reaction due to impurities and adulteration of other organic substances in kerosene. Therefore, perhaps only those persons with some genetic predisposition develop overt manifestations. Further studies are recommended in this regard.

Kailash Kumar
Ram Gulati
CM Kuldeep
Dinesh Mathur
Department of Dermatology and STD SMS Medical College Jaipur, India.

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Photosensitve lichenoid papular sarcoidosis

To the Editor:

A 45-year-old female presented with mildly pruritic erythematous skin lesions over face, forearms and hands of 3 months duration along with history of dyspnoea for the same duration. The lesions were erythematous lichenoid discrete papules predominently distributed over photoexposed areas involving face, dorsal aspect of arms, forearms, and hands with sparing of areas covered by clothing. History of marked photosensitivity was present.

General physical and systemic examinations did not reveal any abnormality. Complete blood count, hepatic and renal functions were normal. Serum calcium was 8 mg%. Mantoux test was negative to 5TU. Rheumatoid factor, antinuclear antibodies and LE cells were negative. However, chest x-ray revealed bilateral hilar lymphadenopathy with diffuse bilateral

reticulonodular shadows alongwith mild basal fibrosis. These findings were further confirmed on CT scan. Pulmonary function test revealed mild restrictive lung disease. A skin biopsy from one of the lesions revealed non-caseating epithelioid cell granulomas with tissue stains for fungus and acid fast bacilli negative. She was given prednisolone 40 mg daily and this led to complete resolution of skin lesions and subjective improvement of dyspnoea in 2 weeks. Patient is still on treatment and follow-up with us.

The cutaneous lesions in our patient were quite suggestive of lichenoid variety of polymorphous light eruption, due to their lichenoid character and photo-distribution. Polymorphic light eruption like lesions have been described previously in sarcoidosis.[1] To the best of our knowledge, marked photosensitivity with lesions strictly restricted to photoexposed areas have not been described in sarcoidosis.

Gurvinder P. Thami
Amrinder J. Kanwar
Mamta
Ritu Jaswal
From the Department of Dermatology, Govt. Medical College, Chandigarh

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