

## LETTERS TO THE EDITOR

### AN UNUSUAL CLINICAL PATTERN OF CONTACT DERMATITIS DUE TO NICKEL-PLATED STRIP ON A BRIEF-CASE

Nickel is present in a variety of articles of every-day use and it is the commonest cause of contact dermatitis due to metals. Different nickel-containing articles produce different but very characteristic clinical patterns of contact dermatitis and most of us are familiar with most of these clinical patterns. There is thus generally no difficulty in recognising nickel as a cause of contact dermatitis. Sometimes however, the pattern of dermatitis can be unusual, if the mode of contact with the nickel-containing article is different. One such patient recently seen by us is described below :

A 50-year-old bank-manager had a 6-month history of itchy papular lesions involving the under-surfaces of both forearms and the medial aspects of the lower halves of the upper arms. The lesions developed first on the medial aspect of the left upper arm near the elbow, and within a month the lesions started appearing in a similar fashion on the right upper arm. Thereafter, the lesions gradually progressed to involve the medial and the under-surfaces of both forearms. Itching was moderate. He also noticed itchy lesions near the left wrist where he was wearing a watch with a metallic case and a metallic strap. Enquiries revealed that he had been carrying a brief case daily for 3 to 4 hours during his travel by bus or train, to cover a distance of 60 kilometers between his place of residence and the office. He used to keep the brief-case vertically on his thighs and rest his upper extremities on it in such a manner that the medial and the under-surfaces of his upper and forearms came in direct contact with the metal lining and the edges of the brief-case. At home and office, his upper extremities used to come in contact with the polished wooden table-tops and

wooden arm-rests of chairs. He was routinely wearing half-sleeve shirts.

Patch testing revealed a 3+ reaction with nickel sulphate, while rubber, rexin of the brief-case, wooden scrapings of the chair, polish of the table-top, cobalt chloride, copper sulphate and potassium dichromate yielded negative results. He was instructed to avoid contact with all nickel-containing articles and especially the brief-case that he was carrying, to apply a topical corticosteroid cream and wear full-sleeve shirts. During follow-up, 2 weeks later, the patient was found to have marked improvement. He was wearing a full-sleeve shirt and he was still carrying the same brief-case. It seems wearing the full-sleeve shirt acted as an effective barrier between his skin and the antigenic article.

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### ANGIOEDEMA DUE TO GUAVA

Urticaria and angioedema due to fruits like grape, plum, pineapple, banana, apple, strawberry and citrus fruits has been recorded,<sup>1</sup> but to our knowledge urticaria and angioedema due to guava has not been reported. We recently saw a 46-year-old government servant who had had 3-4 episodes of angioedema every year for the last 3 years. Each time the swelling would subside within 24 to 48 hours after taking oral antihistamines. There was no variation with the

seasons or the change of place. Exposure to heat, cold, sunlight, pressure, dust or drugs had not been recorded to precipitate the lesions. The last attack however, which occurred 3 months ago developed 3 hours after eating a guava which was bought at an orchard in Allahabad. The lesions had subsided within 24 hours after taking 25 mg pheniramine maleate orally. The patient did not eat guavas subsequently and had no lesions. In order to establish the association, we asked the patient to eat another guava. This time the patient ate a guava bought at a fruit seller's trolley. Six hours later, he developed angioedema on the scalp and the right sole which subsided within 24 hours after taking 25 mg pheniramine maleate orally. He was unable to recall if the attacks of angioedema in the past had occurred after eating guavas. We advised the patient to avoid eating guavas and he has not reported angioedema since then.

It is known that banana contains 5-hydroxytryptamine and excessive intake of bananas can precipitate/aggravate urticarial attacks. It is not known if guava also contains some vasoactive substance. Alternatively, it will be interesting to see if guava contains some histamine liberators which could non-specifically precipitate/aggravate urticarial attacks similar to those caused by aspirin. Our patient, on both the occasions, had eaten unwashed guavas making it possible that some insecticide used for spraying the fruits could also be responsible.

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#### Reference

1. Warin RP and Champion RH : Urticaria, WB Saunders Co, London, 1974; p 50.

## CONTACT DERMATITIS TO BIDI

While reading the article "Contact Dermatitis to Bidi, 1985; 51 : 286", I found certain discrepancies.

The article concludes that the patient was sensitive to tobacco and the likely constituent of tobacco smoke which caused sensitization must be formaldehyde. My objections are : (1) The index and middle fingers of the patient were coming in contact with (a) Bidi leaf, and (b) the paper used for wrapping it, and not with the tobacco, which remains inside these two. Since the patient's fingers were not coming in contact with either tobacco, or its smoke in any way, then how could he develop allergic contact dermatitis with tobacco. Further, if tobacco smoke was sensitizer, then the mucous membrane of lips and oral cavity must also develop dermatitis. (2) If Bidi leaf and paper were sensitizers (although patch test was negative with both these) then besides fingers, lips must also have developed contact dermatitis because lips were also constantly in contact with the Bidi leaf and its paper. But this also was not the case.

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## REPLY

I appreciate the critical reading by Dr. Vora of our article, 'Contact Dermatitis to Bidi'. However, I certainly disagree at the outset with the remark that we have concluded formaldehyde as the likely cause of sensitization in our case. In fact, it is a part of the discussion.

Regarding the unlikeliness of the *Bidi* smoke coming in contact with the fingers of the patients; it is a well known fact that the smokers do deve-

lop brownish yellow staining of the index and middle fingers where bidi or cigarette is usually held.

It is also a common knowledge that contact dermatitis of the oral mucous membranes is rare except on the vermilion border of the lips. During smoking, however, this part is least likely to come in contact with the smoke. Explanations advanced for rarity of allergic contact dermatitis of mucous membrane are : (a) washing off of the antigen rapidly by the secretions, and (b) absence of well keratinised layers on the mucosae.

Routinely, we do patch testing only once, until and unless there is a strong clinical disparity. We agree that in the present situation, ideally, repeat test should have been done, because it was a new observation.

In the present case, we think that the constituents of tobacco in the form of smoke were diffusing out to produce contact dermatitis and so the tobacco gave a positive patch test.

**N L Sharma**