INDIAN J DERMATOL VENEREOL LEPROL 1987; 53 : 248-251

ABSTRACTS FROM CURRENT LITERATURE

Colchicine in the treatment of type 2 lepra reaction, Sharma VK, Kumar B, Kaur I et al : Ind J Leprosy, 1986; 58 : 43-47.

Fifteen lepromatous leprosy patients with type 2 lepra reaction were treated with colchicine. Five had mild, 7 had moderate, and 3 had severe ENL. Colchicine was given for a period of 7 days at a dose of 1-2 mg per day. Clofazimine, corticosteroids and analgesics were avoided during the first week of colchicine trial. Colchicine was found effective in all mild, six moderate and one case of pustular ENL. A maintenance dose of 1 mg per day was given for 1-2 months after the first week. No significant toxicity was observed.

Mercy Paul

A comparative study of the efficacy of WHO and IAL multidrug therapy regimens for leprosy : an in vivo and in vitro study, Revankar CR, Mahadevan PR and Ganapathi R : Ind J Leprosy, 1986; 58 : 543-548.

A laboratory based investigation was done to compare the efficacy of WHO and IAL regimens for the treatment of multibacillary leprosy cases. In each group 4 untreated BL-LL cases were included. A consistent fall in the BI with good clinical improvement was observed in both groups. No significant clinical changes could be seen in patients treated with IAL schedule even during the intensive initial therapy phase as compared to patients treated with WHO regimen after the pulse dose. However, good viability was maintained till about the third pulse dose in WHO group, whereas under the IAL group rapid fall in viability was observed after the intensive phase. The presence of viable bacilli even after 12, 15, 18 and 24 doses in both groups raises doubt about the scientific justification about IAL regimen. Such studies are to be repeated on large samples for further clarification.

N Surendran Pillai

Dermatologic features of fat embolism, Kaplan RP, Grant JN and Kaufman A : Cutis, 1986; 38 : 52-55.

A patient developed fat embolism syndrome following fractures of long bones. The syndrome consists of a triad of pulmonary, neurological and dermatological involvement. Dermatological involvement is manifested by red to brown non-palpable petechiae, occurring within 24 to 36 hours after the injury, over the upper body and resolving in 5 to 7 days. Immobilisation of fracture, oxygen supplementation and systemic corticosteroids are the main modes of treatment.

Mercy Paul

Epidermolysis bullosa : a new sub-group, Eisenberg M, Shorey CD and de Chair-Baker W : Aust J Dermatol, 1986; 27 : 15-18.

A 16-year-old patient with a new mechano-bullous disease is described. Clinically he had features of epidermolysis bullosa, Weber-Cockayne type or mild Koebner type. However, the electron microscopic features resembled those found in the epidermolysis bullosa simplex herpetiformis (Dowling-Meara) type. As the clinical features are not that of classical epidermolysis bullosa simplex herpetiformis type, it is possible that this patient's disease is a mild form of epidermolysis bullosa herpetiformis (DM) or more probably it presents an example of a new quite distinct sub-group of epidermolysis bullosa simplex occurring following a new allelic mutation.

N Surendran Pillai

Heterogeneity of serum IgE levels in atopic dermatitis, Uehara M : Acta Dermatol-Venereol, 1986; 66 : 404-408.

Serum IgE levels were estimated in 139 patients with atopic dermatitis (AD) of whom 50 patients had personal history of atopic respiratory disease (ARD), 37 patients had no personal history of ARD but had family history of ARD, and 52 patients who had neither personal history nor family history of ARD. The latter group of 'pure' AD patients showed significantly lower serum IgE levels than the other two groups of patients. Thus, on the basis of serum IgE producing potential, patients with AD may be classified into atleast two subgroups, (1) those with ARD predisposition who have an enhanced ability for biosynthesis of IgE, and (2) those without ARD predisposition who have a low or not enhanced potential for IgE production.

N Surendran Pillai

Antinuclear antibodies during psoralens plus ultraviolet A (PUVA) therapy : are they worthwhile ? Picascia DD, Rothe M, Goldberg NS et al : J Amer Acad Dermatol, 1987; 16 : 574-577.

PUVA therapy has become an established mode of treatment for psoriasis. Adverse effects reported after PUVA therapy include actinic keratosis, epidermal cell dystrophy, disseminated superficial actinic porokeratosis and various cutaneous neoplasms like squamous cell carcinoma, basal cell carcinoma and keratoacanthomas. Occasional reports of development of significant titers of antinuclear antibodies during PUVA therapy causes great concern because of possible induction of SLE by this treatment.

Here the authors studied 269 patients on PUVA therapy for psoriasis. Five patients had positive ANA prior to PUVA therapy and 22 developed positive ANA during PUVA therapy. This was not statistically significant. Among the patients who developed significantly positive ANA, none was found to have any sign or symptom or laboratory evidence of SLE. The authors suggest obtaining ANA prior to initiating PUVA therapy and obtaining follow-up ANA only if the initial ANA is significantly positive. The authors believe that the case reports of PUVA therapy inducing SLE represent two common diseases occurring in the same patient. If the pre-PUVA ANA is significantly positive and lupus is considered unlikely after an adequate work-up, then PUVA therapy can be initiated with close follow-up of serial ANA.

K Pavithran

Cimetidine in dermatology, Aram H : Internat J Dermatol, 1987; 26 : 161-166.

Cimetidine which is an H_2 receptor antagonist is commonly used now-a-days in peptic ulcer and certain other gastro-intestinal conditions because of its inhibitory action on gastric acid secretion. But its applicability in dermatology is because of its antipruritic, antiviral immuno-restorative and antiandrogenic effects. It is used, (1) in the treatment of chronic urticaria of unknown aetiology. H_2 receptor antagonists are found to be effective when the usual H_1 antihistaminics fail. This is because cutaneous blood vessels contain both H_1 and H_2 receptors. But it should be used in combination with H_1 antagonists, as H_2 blocker when used alone may increase the levels of histamine. (2) In the lympho-proliferative disorders the pruritis is found to be mediated by histamine, cimetidine is thus tried as an antipruritic agent. Enhancement of CMI and the placebo effect are the other factors. Its antipruritic effect is said to be useful in chronic renal failure also. (3) It is also used in refractory infections, mycosis fungoides, malignant melanoma and collagen vascular disorders. Because of its immuno-restorative activity,

cimetidine blocks the H_2 receptors present on some of the T lymphocytes which in turn leads to an increase in the antibody producing cells thus enhancing the cell mediated and humoral immune reactions. (4) In cutaneous T cell lymphoma, because of its antitumour effect. (5) In herpes simplex and herpes zoster because of its antiviral immuno-restorative and antipruritic effects. (6) In hirsuitism in women, it acts as a competitive inhibitor of dihydrotestosterone thus imparting an anti-androgenic effect. (7) In psoriasis, carcinoid flushing, urticaria pigmentosa and systemic mastocytosis. In the last 2 conditions it should be used along with H_1 antagonists. Thus, we can come to a conclusion that, cimetidine can be tried in certain dermatological conditions mainly because of its antihistaminic, anti-pruritic, immunoresteorative, antiviral and anti-androgenic effects.

Anitha K

Treatment of mucoid cysts of fingers and toes by injection of sclerosant, Audebert C : Clin Exp Dermatol, 1986; 11 : 510-513.

The different modalities of treatment available for mucoid cysts of fingers and toes have a high failure rate except for a proper surgical excision and cryotherapy, though it is painful.

Fifteen patients with a total of 16 mucoid cysts of fingers and toes were treated with an injection of several drops of a sclerosant after piercing and evacuation of the cyst content. Three cysts were treated with polidocanol, one with 3% solution and two with 0.5% solution. The remaining 13 cysts were treated with a 3% solution of sodium tetradecyl sulphate. The patients were followed up on 7th day, 30th day and then for two years. The treatment with polidocanol was not satisfactory because it was painful and also it caused haemorrhagic reaction and nail dystrophy. In patients treated with sodium tetradecyl sulphate no complications were noted except for minimal skin necrosis which healed completely in 2-4 weeks time. Treatment with sclerosant injection should be the treatment of choice for mucoid cysts because of its high cure rate, low cost and easy availability. Moreover, it is a rapid and painless technique. The mechanism of action is probably by obstructing the communicating tract which pumps synovial fluid from the joint into the cyst.

Mollykutty Francis

Bullous pemphigoid controlled by tetracycline, Thornfeldt CR and Menkes AW : J Amer Acad Dermatol, 1987; 16 : 305-310.

In two men with non-scarring persistent localised bullous pemphigoid the eruption could be completely controlled with daily doses of oral tetracycline; initially with 500-1000 mg in divided doses and then with a single maintenance dose of 250-500 mg daily. With this regimen the disease could be controlled for over one year. Tetracycline may be used either as a sole therapeutic agent or as a systemic corticosteroid sparing agent. It blocks the bacterial protein synthesis by competitively inhibiting the binding of transfer RNA to messenger RNA. It has anti-inflammatory effect also.

A brief review of literature on persistent localised bullous pemphigoid is also discussed.

Mollykutty Francis

Clofazimine—an effective treatment for Melkersson-Rosenthal syndrome or Miescher's cheilitis, Podmore P and Burrows D : Clin Exp Dermatol, 1986; 11 : 173-178.

Melkersson-Rosenthal syndrome is a rare condition characterised by recurrent facial oedema which eventually becomes permanent, lower motor neuron type of facial palsy and fissuring of the tongue. Infections either bacterial or viral, allergic response, basal arach-

noiditis and vasomotor disturbance of the vasa vasorum of the facial nerve are some of the postulated aetiologies. Miescher's granulomatous cheilitis where there is swelling of one or both the lips is accepted as an oligosymptomatic form of Melkersson-Rosenthal syndrome.

Three cases of histopathologically proved Melkersson-Rosenthal syndrome and one case of Miescher's granulomatous cheilitis were treated with clofazimine in a dose of 100 mg twice daily for 10 days followed by 100 mg twice weekly for four months. Repeat biopsy after 4 months showed complete clearance of granuloma, but persistance of oedema and in some, mononuclear infiltrate. Patients were followed up for six months after stopping the treatment and there was no clinical deterioration. No side effects were noted except for nausea and vomiting in one patient and reversible hyperpigmentation in another.

Mollykutty Francis

Cutaneous manifestations of Corynebacterium group JK sepsis, Jerdan MS, Smith NB and Hood AF : J Amer Acad Dermatol, 1987; 16 : 444-447.

The clinical and histopathologic manifestations of cutaneous emboli associated with corynebacterium group JK sepsis in a 14-year-old boy with acute lymphatic leukamia are reported. The boy developed generalised erythematous macular and papular eruption following chemotherapy. Histopathology of the skin lesions showed effacement of eccrine glands by Gram positive pleomorphic bacilli morphologically consistent with corynebacterium which was confirmed by culture.

Group JK bacteria are a part of normal skin flora and they represent resident lipophilic coryneforms that have acquired antibiotic resistance. It can cause serious infection in immunocompromised and in patients with prosthetic heart valves.

Mollykutty Francis

Risk of herpes zoster in children with leukemia. Varicella vaccine compared with history of chicken pox, Brunell PA, Taylor-Wiedeman J, Geiser CF et al : Paediatrics, 1986; 77 : 53-56.

Varicella-zoster virus is a herpes virus and as such produces a latent infection. Activation of latent varicella-zoster virus results in herpes zoster which is most common in the elderly and the immunocompromised. A live varicella vaccine has been shown to protect children with acute lymphatic leukaemia against varicella. Here the authors undertook a study to determine whether children immunised with live varicella vaccine are at greater risk of acquiring herpes zoster than children who have had varicella. Children with acute lymphocytic leukemia who received live varicella vaccine were compared with children who had natural infection with varicella virus. During the period of observation, 15 of 73 children who had varicella acquired herpes zoster, and none of the 34 children who had been vaccinated. This study shows that recipients of live varicella vaccine are not at increased risk for developing herpes zoster.

K Pavithran