were normal, though immunodiffusion testing gave a positive result at sample dilutions of up to 1/512. Two years after the end of treatment, clinical appearance and radiographic findings remained unchanged. Multitest results have remained negative throughout the entire period.

DISCUSSION

Paracoccidioidomycosis is a common disease in a number of South American countries, most notably Venezuela, Brazil and Colombia. In these countries it generally begins as a respiratory disorder, often with mucocutaneous manifestations. Usually it is separated into five clinical pictures: (a) primary benign disease with self-limiting and asymptomatic pulmonary involvement, (b) acute and chronic progressive pulmonary form, (c) disseminated form with mucocutaneous manifestations, (d) chronic disseminated form with extracutaneous foci, and (e) disseminated infantile form (1, 2). Most cases of imported paracoccidioidomycosis reported in the literature appear to be of forms (a) and (d), both of which may unroll latencies for long periods with a delayed endogenous activation many years later (1).

The length of the latency period (up to 60 years) and the rarity of this disease in non-endemic areas make diagnosis difficult; indeed, many of the cases reported in the literature were previously misdiagnosed as tuberculosis, blastomycosis, epidermoid carcinoma, Wegener's granulomatosis, syphilis, sarcoidosis or leishmaniasis (1, 3).

Full immunological studies of patients with paracoccidioidomycosis have only recently appeared in the literature, and most of these studies deal with patients in endemic areas. In such studies, chronic mucocutaneous forms of the disorder have generally been reported to have latencies of 1–8 years (4). Most reported cases of imported paracoccidioidomycosis are of the chronic mucocutaneous form, but in such cases the period of latency tends to be longer than 7 years and may be up to 60 years (1). Cases previously reported in our region (Galicia, northwest Spain, a region with large numbers of emigrants returned from South America) have had latency periods of between 7 and 32 years (1, 5). In the case reported here, the latency period was 30 years. We consider that the differences in immunological findings between this case and the cases reported previously (4) may be attributable to differences in the latency period: the immune status of patients in which the disease has remained quiescent for a very long period (over 10 years) must necessarily differ from that of patients with a shorter quiescent period.

A number of triazole compounds (including itraconazole, fluconazole and SCH 39304) have previously been used for treatment of paracoccidioidomycosis (6, 7). In most cases in which treatment with these drugs is successful, cell-mediated immunity appears to improve (5, 6, 8). However, anti-Paracoccidioidomyces antibodies may remain detectable even after prolonged treatment (9). In the present case, treatment led to rapid clinical and radiological improvement and to reduced anti-Paracoccidioidomyces serum antibody levels. Despite this, the results of the multitest continued to indicate anergy.

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Cutaneous Horn in a Lesion of Prurigo Nodularis

Sir,

Cutaneous horns are a rare outgrowth of keratin, due to marked retention of stratum corneum. It usually occurs in sun-exposed areas after the fifth decade of life. The retention of the stratum corneum is seen in a number of underlying primary diseases of benign, premalignant and malignant nature (1, 2). We here report a patient with cutaneous horn, originating from a lesion of prurigo nodularis, which has earlier not been described.

A 42-year-old housewife had had multiple severely itchy papules and nodules on her upper and lower extremities for

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Fig. 1. Cutaneous horn in a lesion of prurigo nodularis.

12 years. The lesions had gradually increased in size, with occasional appearance of new lesions. There was no history of constitutional or systemic symptoms. Cutaneous examination revealed multiple 0.5 cm to 1.5 cm size dark brown discrete, firm, hemispherical, keratotic, non-tender papules and nodules, predominantly on the extensors of the forearms and legs and dorsa of the hands and feet. A few lesions were present on the palms, upper arms, flexors of the forearms and thighs also. Some lesions were excoriated, with central depigmentation. There was a solitary, hard, thick, non-tender, keratotic, accumulate gradually increasing lesion projecting about 1.5 cm above the surface of a nodular lesion present on the medial aspect of the right wrist (Fig. 1). She was diagnosed to be a patient of extensive prurigo nodularis with a solitary cutaneous horn. Histopathological examination after an excision biopsy of the horny lesion revealed massive hyperkeratosis with moderate acanthosis and papillomatosis of the epidermis. The dermis showed a mild mononuclear cell inflammatory infiltrate. The features were consistent with cutaneous horn on a lesion of prurigo nodularis.

Cutaneous horn is a benign growth due to excessive retention of stratum corneum. The factors which lead to this massive retention of the horny layer are poorly understood. Probably an underlying chronic irritation and inflammation causes an alteration in normal epidermal activity.

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Wound Healing with a New Growth Factor Formula

Sir,

Venous ulcers continue to be a major socioeconomic burden. The prevalence has been estimated to be as high as 0.5% of the total population. The etiology of these ulcers has not been fully elucidated. At present, the ulcers are normally treated at out-clinics or by district nurses, costing an enormously large amount of money. Many treatment modalities are currently available for wound healing, such as dressings, foams, creams and ointments. Normally, patients are also treated with compression bandages. However, many of the wounds continue to be a burden for patient and doctor.

The culturing of human cells has been developed in an effort to provide a biological covering of epidermal cells over extensive burn wounds (1). The optimal culture medium gel for keratinocytes contains amino-acids, vitamins, sugars, inorganic salt, trace elements, growth hormone, insulin, triiodothyronine and transferrin. Recently a new wound healing gel, “Carioel Dermal” (Life Medical Sciences, New York, USA), has been developed containing all these elements. This gel has been demonstrated to be effective in accelerating the wound healing process in animal studies and unrandomized human studies (2). We set up a well-controlled trial to evaluate the effects of this new formula. In this pilot study we treated two groups: one with the new formula and one with the best standard treatment for leg ulcers, which is in our opinion Comfeel hydrocolloid dressings (Coloplast, Humlehre, Denmark). Dressing changing took place every other day and the patients were treated at home. Each ulcer was diagnosed as a venous leg ulcer by Doppler sonography and light-plethysmography. Each patient was furthermore treated with standard non-elastic compression bandages. Evaluations took place before treatment, at 4 and 8 weeks. Standardized slides were used at each visit. They were processed by a specially designed computer program to analyse the progress in wound healing. The total amount of patients needed to reach statistical significance was calculated at 60 patients in each group.

So far we have treated 10 patients in the study group and 10 in the control group. After 4 and 8 weeks of treatment the study group already showed a mean decrease in wound surface of 201 and 340 mm² (s.d. 211 and 281). In the control group these figures were 164 and 252 mm² (s.d. 147 and 326). Some patients showed a mild maceration around the wound edge, which improved in time. No other side-effects were seen.

The new growth factor gel Carioel Dermal seems to be a new