Prurigo simplex subacuta is a chronic pruritic condition of unknown aetiology. The skin lesions respond to topical corticosteroids, UV-A and UV-B therapy only to a limited degree. Ten patients suffering from prurigo simplex subacuta were treated with foil bath PUVA at a concentration of 0.5 mg 8-methoxypsoralen/L. Using the foil bath method the volume of the psoralen/bath-water solution is restricted to 10L with the aid of polyethylene foil.

The group required a median of 13 (95% CI:9–19) baths for clearance. The total UV-A dose for the whole group was 19 (95% CI:15–30) J/cm². Bath PUVA is a safe and well-tolerated therapy in the treatment of prurigo simplex subacuta. 

Key words: 8-MOP; bath therapy; pruritus.

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**RESULTS**

Patients required a median of 13 (95% CI:9–19) treatments for clearing of the pruritic lesions, the median cumulative dose of UV-A was 19 (95% CI:15–30) J/cm². (Table 1). Two patients with skin type II had minor erythema, no severe side-effects were seen. While 8 patients cleared completely, 2 patients were discharged with minor residual lesions on the legs.

**DISCUSSION**

Prurigo simplex subacuta is a pruritic condition which mainly affects the trunk and the extensor surfaces of the extremities.
<table>
<thead>
<tr>
<th>Sex/age</th>
<th>Skin type</th>
<th>n</th>
<th>Cum. UV-A (J/cm²)</th>
<th>Max. dose (J/cm²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F/73</td>
<td>II</td>
<td>9</td>
<td>4</td>
<td>0.60</td>
</tr>
<tr>
<td>M/85</td>
<td>II</td>
<td>12</td>
<td>11</td>
<td>1.25</td>
</tr>
<tr>
<td>F/80</td>
<td>II</td>
<td>6</td>
<td>5</td>
<td>1.50</td>
</tr>
<tr>
<td>F/52</td>
<td>II</td>
<td>19</td>
<td>23</td>
<td>1.50</td>
</tr>
<tr>
<td>M/55</td>
<td>III</td>
<td>13</td>
<td>19</td>
<td>2.75</td>
</tr>
<tr>
<td>M/35</td>
<td>III</td>
<td>21</td>
<td>17</td>
<td>4.00</td>
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<tr>
<td>M/29</td>
<td>III</td>
<td>14</td>
<td>26</td>
<td>3.30</td>
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<tr>
<td>M/72</td>
<td>III</td>
<td>18</td>
<td>30</td>
<td>2.00</td>
</tr>
<tr>
<td>F/75</td>
<td>III</td>
<td>15</td>
<td>27</td>
<td>2.75</td>
</tr>
</tbody>
</table>

Median: 55 cases, CI: (32–75) cases

The diagnosis is usually based on clinical symptoms and the exclusion of other diagnoses such as atopic dermatitis, contact dermatitis or infections (3). The pathogenesis of the condition is unknown, although some authors have proposed that it is a reaction of the follicular wall (6). To a limited extent, patients may respond to treatment with topical corticosteroids, systemic antihistamines, systemic PUVA therapy and UV-B application (3). Since both PUVA has been reported to have an immunomodulating effect (7), we performed this treatment in our patients resulting in complete or almost complete clearance in all 10 patients.

Bath PUVA has been demonstrated to be a safe and effective treatment modality in the therapy of psoriasis since the first report by Fischer & Aksén in 1976 (8). Other studies have confirmed that bath PUVA compared to systemic PUVA therapy offers the advantage of avoiding systemic side-effects, such as gastrointestinal discomfort and the risk of cutaneous eruptions which may follow standard oral 8-MOP application (9, 10). Furthermore, bath PUVA requires less than 50% of the cumulative UV-A dose per treatment cycle, as calculated in the European PUVA study for systemic PUVA therapy of psoriasis (10, 11).

On account of its safety and efficacy, bath PUVA is gaining an increasingly wide distribution. With the exception of psoriasis, our studies have revealed a positive effect of bath PUVA in the therapy of nodular prurigo (12) and scleroderma (13).

Although the etiology of prurigo simplex subacute is unknown, the beneficial response to bath PUVA in our patients could be explained by immunomodulation, as it has recently been shown in biopsies from psoriatic lesions that epidermal and dermal CD3 + T-lymphocytes, as well as CD4 + and CD8 + and IL-2 receptor + subsets, were strongly suppressed by bath PUVA (7). Other authors have reported a decrease in epidermal Langerhans' cells (14).

The bath method for the application of bath PUVA restricts the volume of bath water from 150–200 l per bath, as commercially available 8-MOP solutions are considerably more expensive than systemic PUVA therapy. Although the number of patients included in this study is limited, the results clearly show that patients suffering from prurigo simplex subacute greatly benefit from bath PUVA. This treatment modality represents a safe and well-tolerated way to treat patients suffering from a condition that proved to be comparatively unresponsive to other therapies.

REFERENCES