LETTERS TO THE EDITOR

Cyclosporin A and Pityriasis Rubra Pilaris

Sir,

The therapeutic activity of cyclosporin A (CyCA) in severe psoriasis is well documented (1, 2, 3). However, it has recently been reported that CyCA had no effect on Pityriasis Rubra Pilaris (PRP) (4). We report here a case of PRP type I showing dramatic improvement of the lesions after CyCA treatment.

A 36-year-old Moroccan man had had palmoplantar keratoderma and follicular papules all over his body since 1985. PRP was clinically diagnosed and confirmed by histological examination. Previous treatments with topical steroids, PUVA and Methotrexate were unsuccessful; Tigason (etretinate) was not tolerated and caused serious hair loss.

In May 1989, the disease became widespread and nearly erythrodermic, with classical islands of apparently normal skin. The patient was hospitalized and treatment with CyCA 5 mg/kg/day (one oral daily dose) was started. A spectacular clinical improvement of his condition was noted during the first week and the patient was completely cleared after 4 weeks of treatment. No side effects were recorded during this period. The patient is still taking 3 mg/kg/day of oral CyCA, and the disease is under control since June 1989, without any relapse so far.

Many workers have observed that epidermal cell renewal is increased in PRP (5, 6). CyCA has been proved to inhibit the proliferation of normal and transformed keratinocytes in vitro (7). This could be the mode of action of CyCA on PRP.

We consider that CyCA is an effective therapeutic remedy for PRP.

REFERENCES


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Silicone Gel in the Treatment of Keloids

Sir.

We were interested to see the results of Juhlin’s recent study in which he found that a hydrocolloid occlusive dressing, combined with various potent corticosteroids, was useful in the management of psoriasis and other dermatoses (1). There has been growing interest in the use of occlusive dressings in the treatment of a variety of dermatological conditions (2, 3, 4) including hypertrophic scarring (5, 6).

We have assessed the potential benefit of silicone gel sheeting (Silastic Gel Sheet, Dow Corning Q7-9119) in the management of keloids, as currently the treatment of this problem is less than satisfactory, in terms of both efficacy and adverse effects. Informed, consenting patients recruited from the Skin Department applied the gel sheeting to their keloid(s) for 24 hours per day, removing it only for bathing, at which
Fig. 1. Keloids prior to (A) and after (B) treatment with silicone gel and clobetasol propionate 0.05% (Dermovate) ointment.

Table I. Demographic data, keloid characteristics, associated symptoms and clinical responses

<table>
<thead>
<tr>
<th>Patient</th>
<th>Cause</th>
<th>Keloid duration (years)</th>
<th>Associated symptoms</th>
<th>Effect of treatment</th>
<th>Length of treatment (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian F 60</td>
<td>Surgery</td>
<td>15</td>
<td>Itching</td>
<td>Itching markedly relieved</td>
<td>3</td>
</tr>
<tr>
<td>Caucasian M 27</td>
<td>Unknown</td>
<td>0.5</td>
<td>Tenderness</td>
<td>Markedly flatter and paler</td>
<td>2</td>
</tr>
<tr>
<td>Negroid M 20</td>
<td>Trauma</td>
<td>4</td>
<td>Slightly flatter</td>
<td>Markedly flatter</td>
<td>1</td>
</tr>
<tr>
<td>Negroid M 23</td>
<td>Insect bite</td>
<td>6</td>
<td>Itching</td>
<td>Itching fully relieved</td>
<td>3</td>
</tr>
<tr>
<td>Negroid F 30</td>
<td>Surgery</td>
<td>1</td>
<td>Slightly flatter</td>
<td>Markedly flatter</td>
<td>3</td>
</tr>
<tr>
<td>Caucasian M 23</td>
<td>Acne vulgaris</td>
<td>4</td>
<td>Tenderness</td>
<td>Tenderness markedly relieved</td>
<td>3</td>
</tr>
<tr>
<td>Caucasian F 15</td>
<td>Chickenpox</td>
<td>0.5</td>
<td>Itching</td>
<td>Markedly flatter and paler</td>
<td>1</td>
</tr>
</tbody>
</table>

Acta Derm Venereol (Stockh) 70
time the gel was changed. Each sheet was cut to a size slightly larger than the keloid itself and held in place with Micropore tape (3M Health Care Ltd.). Patients were reviewed at monthly intervals for up to 3 months. Nine keloids in 7 patients were evaluated and the results are shown in Table I. Initial evidence of benefit was usually observed at the first clinical assessment after one month. Patients found the gel comfortable and easy to use.

We found it quite striking that all patients experienced some benefit, but felt that efficacy would be improved by the concomitant use of a potent topical corticosteroid. Thus, when faced with a distressed female patient, aged 24 years, who had keloid formation of 8 months' duration on her right lower forearm caused by attempting to remove long-standing tattoos with an unidentified acid, the following management was instituted. Clobetasol propionate 0.05% (Dermovate) ointment was applied under silicone gel occlusion daily, using the method described above. Significant improvement in itching, tenderness, colour, texture and thickness was noted at the first review after 3 weeks. The excellent results achieved 3 months after commencing treatment are shown in Fig. 1.

In view of our results, we propose that further work with silicone gel, with or without concomitant corticosteroid application, is warranted. Such treatment may be particularly useful early in keloid development, especially in patients known to be at risk of this problem.

REFERENCES

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On Longitudinal Melanonychia after Healing of Lichen Planus

Sir,

In a short paper published in Acta Dermato-Venereologica (1989; 69: 338) we reported on a patient with lichen planus of the fingernails. After a period of normal fingernail appearance she displayed longitudinal bands of melanonychia. At that time we speculated that the red lunulae which accompanied the longitudinal melanonychia represented a low-grade or a specific type of inflammation which stimulated pigmentation.

About 18 months after our case report was sent for publication we saw the patient again, and she then had normally coloured lunulae and no longitudinal melanonychia. The onycholysis that we had noted on the thumb nail was still present, with a greenish tinge due to Pseudomonas. This case strengthens the view that longitudinal melanonychia may be equivalent of the transitory pigmentation observed when skin lesions of lichen planus are healing.

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