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.

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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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