short reports

Tromyography were normal. Chest X-ray, barium meal, barium enema, intravenous urogram and mammography were normal. Pelvic examination by a gynaecologist was also normal. Skin biopsy showed a vasculitis with overlying sub-acute dermatitis and direct immunofluorescence demonstrated positive immunofluorescence for IgM and C₃ in superficial vessels and patchily along the dermo-epidermal junction. Muscle biopsy was not performed.

All therapy was stopped and over the next 2 months the rash gradually faded and a feeling of well-being returned; at no time was there a clinically evident weakness of muscles, but 24 h urinary creatinine levels remained elevated at 1140 µmol even after 9 months.

Discussion

This 50-year-old lady presented with the characteristic rash of dermatomyositis and biochemical (but not clinical) evidence of myopathy. Muscle biopsy was not performed in our patient because of the normal electromyograph and lack of muscle symptoms. The diagnosis of myositis in this patient is based on the elevated level of creatine in the urine. Several authors (7, 8) cite this test (urinary creatine) as the best index of disease activity. Serum glutamic oxaloacetic transaminase (SGOT), serum aldolase and serum creatine phosphokinase may also be elevated, but some patients continue to show activity in the presence of normal levels (7).

We cannot explain why our patient's urinary creatine is still abnormal, while the dermatological features have resolved. It could be suggested that she has both rheumatoid arthritis and polymyositis. The association between these two disorders has been established (6), but none of the patients in this series had dermatological manifestations.

There has been one previous case report of dermatomyositis occurring during D-Penicillamine therapy (4) though there are several differences between the two cases. The patient concerned received up to five times the daily dosage taken by our patient, she developed a high titre of antinuclear factor and required systemic therapy with Prednisolone to induce a remission of dermatomyositis.

We suggest that our patient had both rheumatoid arthritis and dermatomyositis and that, because of the rapid remission of the rash on withdrawal of D-Penicillamine, the drug was the causative factor, especially as investigations for neoplasia and an 18-month follow-up have revealed no other associated conditions.

References


Local Photochemotherapy in Nodular Prurigo

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Abstract. Fifteen patients with nodular prurigo were treated with a trioxsalen bath (50 mg/150 l of water) and UVA given in an ordinary PUVA cabin. Good results were observed in 8 and moderate in 7 patients in the initial phase. The result was good or excellent in 13 of the 15 patients during maintenance treatment. The good results are promising in the treatment of this chronic and otherwise therapy-resistant disease.

Key words: Nodular prurigo; Itching; Photochemotherapy; Trioxsalen; PUVA

Nodular prurigo (syn. Prurigo nodularis Hyde, Lichen comeus obtusus) is seen most often in middle-aged women. The exact cause and mechanism of this fairly rare disease are unknown. It may be some kind of cutaneous neurosis with intense itch-
ING LEADING TO CONTINUOUS SCRATCHING, TEASING AND TUGGING OF THE SKIN.

TREATMENT OF NODULAR PRURIGO HAS BEEN VERY LIMITED. LOCAL CORTICOSTEROIDS AS OINTMENTS OR AS INTRAESIONAL INJECTIONS HAVE BEEN MOST BENEFICIAL (7) BUT RELAPSES ARE VERY FREQUENT. TRANQUILIZERS AND PSYCHIATRIC ASSESSMENT HAVE THEREFORE ALSO BEEN USED.

THE INTRODUCTION OF PUVA THERAPY FOR THE TREATMENT OF CHRONIC SKIN DISEASES RESPONDING POORLY TO 'CLASSICAL FORMS OF TREATMENT HAS CHANGED THE PROGNOSIS FOR MANY OF THEM. WE USED LOCAL PHOTOCHROMOTHERAPY IN 15 PATIENTS WITH NODULAR PRURIGO OVER A 14-MONTH PERIOD. THE INITIAL RESULTS WERE GOOD AND THIS THERAPY WOULD ALSO SEEM TO HAVE ALTERED THE OVERALL PROGNOSIS FOR THIS TROUBLESOME DISEASE.

PATIENTS AND METHODS


LOCAL PUVA THERAPY WAS GIVEN AS DESCRIBED EARLIER (4). FIFTY MG OF TRIOXXALLEN (FERMION, FINLAND) IN 20 ML OF ETHANOL WAS ADDED TO 150 L OF WARM (37 °C) WATER. THE PATIENTS BATHED FOR 10 MINUTES. UV A WAS GIVEN IMMEDIATELY AFTER THE BATH IN A STAND-UP PUVA CABIN (PUVA 22, ASTRA-SJÖCO, HELSINKI) GIVING ABOUT 12 MW/Cm² OF UV A. THE INITIAL DOSE WAS 0.12 J/Cm² IN 6 PATIENTS AND 0.24 J/Cm² IN 9. THE PATIENTS WERE ALL TREATED DAILY, AND THE DOSE WAS INCREASED EVERY THIRD DAY BY ABOUT 50%, I.E. FROM 0.12 TO 0.18, 0.24, 0.36, 0.54, 0.72 J ETC. UNLESS BURNING OR OTHER UNTOWARD SIDE EFFECTS WERE NOTED. THE TREATMENT WAS CONTINUED UNTIL BENEFICIAL RESULTS WERE SEEN, WHICH TOOK 1-4 WEEKS. THEREAFTER THE PATIENTS WERE KEPT ON MAINTENANCE THERAPY FOR AN AVERAGE OF 5 MONTHS (1-13 MONTHS). THE MAINTENANCE THERAPY WAS GIVEN AT 1-2 MONTH INTERVALS, ON 2-4 CONSECUTIVE DAYS EACH TIME. THE MAINTENANCE DOSE WAS APPROXIMATELY THE DOSE ACHIEVED DURING THE INITIAL TREATMENT PHASE.

THE TOTAL DOSE OF UV A DURING THE INITIAL TREATMENT PHASE WAS ON AVERAGE 14.6 J/Cm² AND DURING THE MAINTENANCE THERAPY 12.2 J/Cm² (MAXIMUM 29.3 J/Cm² IN CASE 4). ROUTINE BLOOD AND URINE TESTS AND SERUM ALANINE AMINO TRANSFERASE (S-SALT) WERE DETERMINED BEFORE THE TREATMENT AND AT 2-4 WEEK INTERVALS DURING THE INITIAL THERAPY AS WELL AS AT 1-2 MONTH INTERVALS DURING THE MAINTENANCE THERAPY.

RESULTS

AN AVERAGE OF 3 WEEKS WAS NEEDED TO ACHIEVE MODERATE OR GOOD RESULTS DURING THE INITIAL TREATMENT.
phase (Table I). None of the 15 patients failed to react to this therapy. The clinical healing took place in two phases. Within 4-6 days, itching decreased markedly or disappeared completely. The induration also regressed noticeably during the first week but to a much lesser extent during the following 1-2 weeks. The lesions continued to heal during the maintenance therapy (Figs. 1, 2). Once an excellent result had been achieved, the nodules grew again in only 2 cases. These patients (cases 1 and 11) complained of increasing itching towards the end of the interval between maintenance therapies.

So far, therapy has been discontinued in 4 cases. One of them (case 11) has stopped the treatment after 6 months of maintenance therapy because of the long distance between the hospital and her home. In 3 other cases (3, 6 and 7) the result during the maintenance therapy was so good that further treatment was considered unnecessary. The follow-up period is, however, so short (only 2-4 months) that no conclusions about the long-term effect of photochemotherapy can be drawn.

Undesirable side effects were encountered in 7 patients during the initial treatment, grade I burning in 6 cases and blistering in one. During the maintenance therapy the corresponding figures were 4 cases of grade I burning and one case of blistering. All these side effects disappeared in 1-3 days, and the treatment was continued. In laboratory tests, no pathological changes possibly due to the photochemotherapy were found. No other side effects, local or systemic, were seen, either.
DISCUSSION

Photochemotherapy has been used in some diseases in which itching is one of the most disturbing symptoms, e.g. in lichen planus (6) and in atopic dermatitis (3, 5) with good results in both complaints. Since itching is the main symptom in nodular prurigo as well, we decided to try photochemotherapy for its treatment. We tried trioxsalen bath instead of systemic methoxsalen because trioxsalen bath plus UVA has proved effective and safe in the treatment of psoriasis (1, 4).

Our results during both initial and maintenance therapy were unexpectedly good. The mode of action of the therapy may be triphasic. First of all, photochemotherapy blocks the rapid turnover in epidermal cells. This reduction leads to a reduction of the pseudoepitheliomatous hyperplasia of the epidermis. The treatment also reduces the numbers of inflammatory cells in the dermis. The main effect of photochemotherapy in nodular prurigo seems to consist in breaking the vicious circle of itching and scratching.

Local application of the photosensitizing drug is more advisable than the systemic mode because it is obviously only with difficulty that the drug reaches the lesions when given perorally. The pharmacological basis of the beneficial effect remains obscure. The mechanism may be of the same type as that seen in the treatment of pruritus in uraemia with UVB (2), whatever it might be.

REFERENCES


Induction of Delayed-Type Sensitivity to Leishmania Parasite in a Case of Leishmaniasis Cutanea Diffusa with BCG and Cord-Factor (Trehalose-6-6’ Dimycolate)

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Abstract. The delayed hypersensitivity against the leishmania parasite was restored to a patient who had suffered from diffuse cutaneous leishmaniasis (DCL) for 26 years, by the application of an ointment containing heat-killed and lyophilized BCG and cord-factor (trehalose-6-6’-dimycolate) after stripping the affected and adjacent areas with scotch-tape.

A 46-year-old Patient, suffering from leishmaniais lesions on the nose, cheeks and upper lip which appeared 26 years ago, was hospitalized in our department. According to his history, 11 years before the appearance of these lesions he suffered from leishmaniasis nodosa localized to the lower and flexor side of his right arm, where a scar can be seen. During these 26 years, he was treated with all known therapeutic modalities, including five surgical interventions, with no beneficial effect: the lesions merely reappeared and multiplied (Fig. 2).

In the repeated microscopical examinations,