

ministered was 0.60 ± 0.06 , the average MPD (Joule/cm²) being 2.6 ± 1.5 .

No definite correlation was found between 1) the doses of 8-MOP ingested and the 8-MOP serum level, 2) the 8-MOP serum level and the MPD, or 3) the doses of 8-MOP ingested and the MPD.

DISCUSSION

This study demonstrates that 8-MOP serum levels, determined 2 hours after oral administration of the drug, vary considerably in different psoriatic patients. Moreover, no definite correlation was found between MPD and 8-MOP serum level, thus indicating that the patient's individual sensitivity to PUVA depending on the skin type, is of major importance in the phototoxic response to 8-MOP.

Since in addition no correlation exists between the 8-MOP serum level 2 hours after 8-MOP administration and the dose of 8-MOP per kg body weight administered, a variable resorption and/or excretion rate for 8-MOP may be assumed, differing from one psoriatic patient to another.

Our failure to demonstrate a correlation between the three different parameters investigated in this study underlines the importance and absolute necessity of phototesting (4) prior to PUVA treatment.

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Periodic, Functional Disuse of Limbs: Report of a Case

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Abstract. The case is presented of a patient who developed periodic loss of function in individual limbs, and associated cyanosis and hyperkeratosis. Investigation excluded organic disease, and the condition responded to physiotherapy.

Key words: Functional disuse; Cyanosis; Hyperkeratosis

Prolonged inactivity of a limb may induce oedema, cyanosis, hyperkeratosis and ulceration. The appearance may mimic a number of cutaneous, neurological and vascular disorders.

CASE REPORT

A 16-year-old boy was referred in November 1974 with a 12-month history of periodic attacks of cyanosis, coldness and weakness affecting the right hand. These attacks began immediately after a fall on the right elbow, although there had been no fracture nor ulnar nerve injury. The patient was a non-smoker; there was no history of exposure to ergot, vinyl chloride or vibrating machinery.

By October 1975 the right arm had gradually returned to normal, but similar episodes affected the left leg. The problems with his limbs forced our patient to lose jobs as a gardener and hotel porter.

In March 1976 the left arm was involved, an episode which persisted for 6 months. Below the elbow, the arm became cold, swollen and blue. Hyperkeratosis of the hand and forearm developed (Fig. 1). Peripheral pulses were normal. There was subjective sensory impairment, but no objective sensory loss. Power of all muscle groups was normal, although use of the limb produced considerable discomfort. There were no signs attributable to parietal lobe dysfunction. After a period of observation it became clear that the patient was neglecting the affected arm; it was carried limply by his side and the patient (a nail biter) ceased to bite the nails of his left hand.

Routine investigations gave either normal or non-contributory findings. Skull X-ray, Brain Scan, E.E.G. and right subclavian and brachial arteriography were also normal. Sweating tests indicated no disturbance of central, peripheral or end-organ mechanisms. Skin thermometry indicated that the basal temperatures were only low in the limbs when they were clinically affected; reflex vasodilation in the hands was normal at all times.

The patient formed a good relationship with his physicians and the medical social worker. Although quiet and



Fig. 1. Hyperkeratosis and unbitten nails of the left hand.

diffident he was judged to be of normal intelligence, and no specific stress factors could be isolated. Intensive, active physiotherapy resulted in the limb returning to normal within 2 weeks. To date, 9 months later, there has been no relapse.

DISCUSSION

Twenty years ago MacAlpine & Ross (1) drew attention to Charcot's description of *Oedeme Bleu des Hystérique*. He observed that oedema, coldness and altered sensation characterized the disorder. Perhaps the most characteristic feature of hysteric sensory loss is that neurological impairment corresponds to the patient's ideas of anatomy, rather than his Doctor's. The prognosis is generally poor. Our patient manifested sensory inattention rather than loss. He was co-operative, pleasant and sensible, and could not be described as having an hysterical personality. The vascular changes were far more prominent than the neurological signs. In all, three limbs were involved and although initially embolism or vasculitis were possibilities, these diagnoses were not confirmed.

We believe that this patient has periodic functional disuse of limbs. A term which best describes his symptoms and their development. Functional disuse of a limb should be recognized as a cause of oedema, cyanosis and hyperkeratosis—and a cause which is amenable to simple treatment with active physiotherapy.

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Oral Injury Caused by Fellatio

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Abstract. A 34-year-old Caucasian woman is presented with a circular hemorrhagic lesion located on the soft palate and caused by fellatio. The lesion consisted of erythema, petechiae, dilated blood vessels and vesicles. It healed in a few days. No evidence of the major clinical alternatives such as thrombocytopenia, venereal disease, candida infection or pathomimia were found. Injuries due to fellatio must be considered as an etiological factor to hemorrhagic changes of the oral mucosa, and with a positive history, patients can be spared from other investigations.

Key words: Fellatio; Oral lesion; Palatal purpura

Lesions of the oral mucosa due to orogenital contact are reported to be mostly caused by venereal diseases (3, 10). Physical consequences of oral sexual practice are rarely mentioned, but even in 1928, Barthélemy (1), and in 1949, Rattner (8) reported on "A strange case of palatitis". Since then, further attention has been focused on the association be-

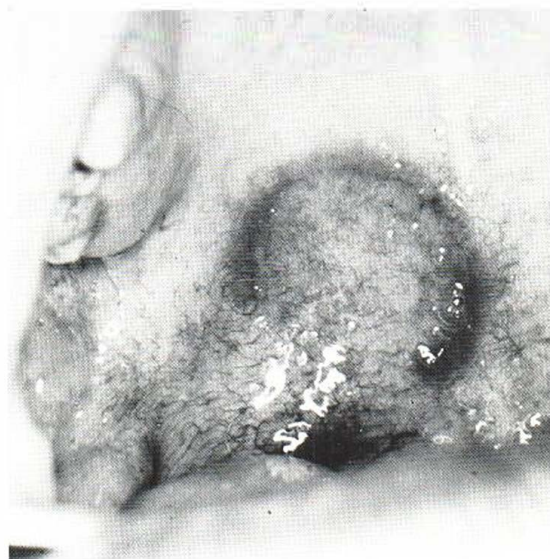


Fig. 1. Purpuric and erythematous lesion of the soft palate. Note petechiae and dilated blood vessels.