

LETTERS TO THE EDITOR

Serum IgE Levels in Patients with Bullous Pemphigoid

I would like to react on the interesting report of Eva Åsbrink and Anders Hovmark, concerning serum IgE levels in patients with bullous pemphigoid (BP) (1). On this subject we reported in 1980 (2). Concerning the relationship between the serum IgE levels and the anti-BMZ antibody titers our results somewhat differ from those reported by the authors (see Table I). This difference may be explained from the stage of the disease. Unlike the patients of Åsbrink and Hovmark several of our patients did not show an acute exacerbation when the blood samples were taken.

Table I. Serum IgE levels and anti-BMZ antibody titers in 28 patients with BP

Anti-BMZ antibody titers	IgE (kU/l)		
	120	120-400	>400
1/10	3	3	1
1/20-1/60	4	1	3
1/320	1	2	2
1/640	1	2	4

More important is the question about the relevance of IgE in BP. The main biological function of the interaction of IgE and antigens is to mediate the release of inflammatory factors from mastcells. In our study we pointed out that there is no relation between serum IgE levels and IgE-positive mastcells on the one side and extent of eruption, erythema and eosinophilis in the blood and diseased tissue on the other. This, together with the relatively high percentage (63%) of not clearly elevated serum IgE levels, i.e. less than 400 kU/l, prompted us to the conclusion that IgE does not play an important role in the pathogenesis of BP.

Now the question arises if one can use IgE, being a non-specific parameter, as a sign for disease-specific activity, in the same way as e.g. the ESR is used in infectious or malignant diseases. In the latter case the clinician will always consider the possibility of an intercurrent infection causing an elevation of the ESR. In the same way a rise of the serum IgE level may be the non-specific, concomittant result of viral (3, 4) or bacterial (5) infections. In most instances the clinical symptoms like the reappearance of itch or a few new lesions will sufficiently warn the clinician that the disease is not well under control. So the use of the serum IgE-levels as a parameter in BP does not seem useful on theoretical and practical grounds.

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Treatment of Alopecia areata with Diphenylcyclopropenone

For some time now diphenylcyclopropenone has been used in the treatment of alopecia areata with great success (1, 3). Based on our clinical experiences we now want to point out that in therapy-resistant cases the treatment should not be discontinued after 20 weeks as previously recommended (2). This suggestion is based upon the observation that during the course of treatment three of our patients showed beginning of hair growth as late as 6-8 months after treatment was started. A spontaneous remission in these cases does not seem probable since hair growth was confined to treated areas alone.

We also wish to point out an interesting phenomenon, for which we have no explanation so far. Three patients also showed regrowth of non-treated eyebrows and eyelashes 4-5 months after hair regrowth on the scalp (Figs. 1-3), whereas in other areas of the body, especially axilla and pubic region, alopecia persisted. Possibly a transport of the contact allergen to close skin regions led to a reaction with perifollicular sensitized T-lymphocytes, which might be essential for the initiation of hair regrowth (5).

After successful induction of a contact eczema and continuous treatment for several months two of our patients surprisingly lost their sensitivity towards diphenylcyclopropenone on the scalp and did not even respond to the application of high concentrations. However, they were very well able to develop a contact eczema on the arm after the application of a concentration as low as 0.01%. This phenomenon may resemble so-called "hardening". Unfortunately in both these cases treatment had to be discontinued because there was no response.

It seems important to emphasize that diphenylcyclopropenone is a very potent contact allergen (4). Therefore in general it is not advisable to give it to patients for self-treatment. Inappropriate self-treatment may cause severe generalized eczema making the patients hospitalization necessary. In any case the treatment should be supervised by a doctor continually.

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