Transient increase in plasma histamin levels have been documented in patients with cholinergic urticaria and exercise-induced anaphylaxis (2, 3, 5), but we found no clinical beneficial effect of H₁ or H₂ antihistamine drugs. Further no therapeutic effect was seen during treatment with betasymptomimetics and anticholinergics.

The anaphylactic attack provoked by the warm bath was most severe, and could have been life threatening. For this reason we find it important to warn patients with exercise induced anaphylaxis of the possibility of a severe anaphylactic reaction after heating.

REFERENCES

Psoriasis Provoked by β-Blocking Agents

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23 patients suffering from psoriasis and being treated with β-blocking agents were compared to a control group regarding psoriasis activity. Seven out of the 23 were affected by psoriasis after introduction of the β-blocking drug. The mean age of onset was significantly higher (p<0.001) than that of the control group, which supports the provoking effects of β-blocking agents. Remission occurred in 3 out of 4 patients after medication was stopped.

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Ten years ago Ridley (1) reported psoriasiform dermatoses as a side effect of treatment with the β-blocking agent practolol. Two years later Sundergaard and co-workers (2) reported aggravation of psoriasis due to the same drug. Healing or marked improvement occurred, however, when practolol treatment was stopped. In the recent years other β-blocking agents have been reported to induce psoriasiform dermatoses as a side effect (3). Provocation of psoriasis has not been reported. We therefore call the attention to our findings that 7 out of 23 psoriatics on β-blocking agents got their psoriasis after the drug was introduced.

PATIENTS AND METHODS

23 patients suffering from psoriasis and taking β-blocking agents, were interviewed about acticity of their psoriasis in relation to the medication (group I). As controls served 25 patients with psoriasis not
using β-blocking agents (group III). This group was matched to the characteristics of group I regarding age, sex and intensity and extension of skin lesions.

Statistical analysis was carried out with the Student’s t test.

RESULTS

In seven patients (4 men and 3 women) of group I (psoriasis and β-blocking agents) the diagnosis of psoriasis was made after introduction of β-blocking drugs (Table 1). The average age of onset was 60.3 years (43–80). This was significantly higher than in the other group (p<0.001). The period of latency from a β-blocking drug was given until outbreak of psoriasis averaged 1.8 years (½–5 years). The intensity of psoriasis was slight in 1, moderate in 2 while 4 patients had generalized psoriasis.

In 4 out of the 7 patients the medication was stopped. Their cardiac situation was carefully monitored by the internist. Three of these patients experienced remission after 2½–6 months.

21 patients in group I reported periods of aggravation the last 2–3 years. 23 patients in group II (psoriatics not taking β-blocking agents) had periods of aggravation during the same time. In both groups periods of aggravation were ascribed to causes like stress, infections and winter climate, but in some patients aggravation could not be related to a specific cause.

DISCUSSION

Most psoriatics report periods of aggravation without being able to relate that to any specific known provoking factor. Accordingly, it may be difficult to evaluate aggravation of psoriasis by a certain drug. The age of onset in the 7 patients who were affected by psoriasis after starting β-blocking medication is, however, remarkably high compared to previous reports (4). It is significantly higher (p<0.001) in the group taking β-blocking drugs compared to the other group. Only in 2.7% of psoriatics the disease starts after the age of 50 (4), compared to 30.4% in group I. From this it may be concluded that it is probable that psoriasis in these patients was provoked by the β-blocking agents. Other additional aggravating factors may explain the long latency (1.8 years) from start of β-blocking medication until outbreak of psoriasis.

The contraindication of β-blocking medication in psoriatics is only relative. The cardiac situation must be most carefully considered. However, after stopping β-blocking medication remission occurred within 2½–6 months in 3 out of 4 cases.

Intracellular cyclic adenosine monophosphate (cAMP) is lowered by β-blocking agents (3). This increases the ratio between cyclic guanosine monophosphate (cGMP) and cAMP which may be responsible for increased epidermal proliferation in psoriasis (5).

Table 1. The different β-blocking agents taken by 23 psoriasis patients

<table>
<thead>
<tr>
<th>Registered name</th>
<th>Generic name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apterin®</td>
<td>Alprenolol</td>
</tr>
<tr>
<td>Bloxadren®</td>
<td>Timolol</td>
</tr>
<tr>
<td>Eraldin®</td>
<td>Practolol</td>
</tr>
<tr>
<td>Inderal®</td>
<td>Propranolol</td>
</tr>
<tr>
<td>Seloken®</td>
<td>Metoprolol</td>
</tr>
<tr>
<td>Tenormin®</td>
<td>Atenolol</td>
</tr>
<tr>
<td>Viskén®</td>
<td>Pindolol</td>
</tr>
</tbody>
</table>
REFERENCES

Acrogeria with Perforating Elastoma and Bony Abnormalities
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Department of Dermatology, Mayo Clinic and Mayo Foundation, Rochester, Minnesota, USA

Venencie PY, Powell FC, Winkelmann RK. Acrogeria with perforating elastoma and bony abnormalities. Acta Derm Venereol (Stockh) 1984; 64: 348-351.

A case of acrogeria, a premature aging syndrome with acral distribution, is reported in association with perforating elastoma and bony abnormalities. Key words: Premature aging syndrome; Atrophy of the skin; Hyperpigmentation. (Received December 6, 1983.)

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Acrogeria is a rare developmental defect first described by Gottron in 1941 (1). Since then, more than 20 cases have been reported, pointing out interesting associations, including perforating elastoma and bony abnormalities.

REPORT OF A CASE
A 14-year-old mentally retarded white boy was seen at the Mayo Clinic in 1959. He had a 3-year history of asymptomatic, grouped, horny, red papules with an annular configuration on the left side of the neck, just below the posterior hairline (Fig. 1).

On clinical examination, the skin was found to be diffusely atrophic and hyperpigmented, with atrophy most pronounced on the extremities. The hands were small and hyperpigmented, with spindle-shaped fingers, and the venous pattern was readily visible because of the atrophic skin (Fig. 2A). The feet were small, with atrophic wrinkling of the skin, varus deformation of the right foot, and dystrophic toenails (Fig. 2B). The nose was pinched. A deep venous pattern was seen on the anterior aspect of the upper trunk. and there was moderate gynecomastia. The fingernails, hair, and dentition were normal. No joint hypermobility or skin hyperextensibility was noted. The family history was negative for acrogeria, and there was no history of consanguinity. The personal history was difficult to obtain from this mentally retarded patient, but the mother had noted “thin skin” from birth and easy bruising of the skin. Bone roentgenograms showed varus deformity of the right foot, congenital dislocation and elongation of the right radial head at the elbow, deformity of the left radioulnar joint with shortening of the ulna, cervical and lumbar scoliosis, and spina bifida occulta. Results of an eye examination were normal. A hemogram, sedimentation rate, and blood chemistry values were normal. A biopsy specimen of a skin lesion in the neck showed elastosis of the papillary dermis and

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