

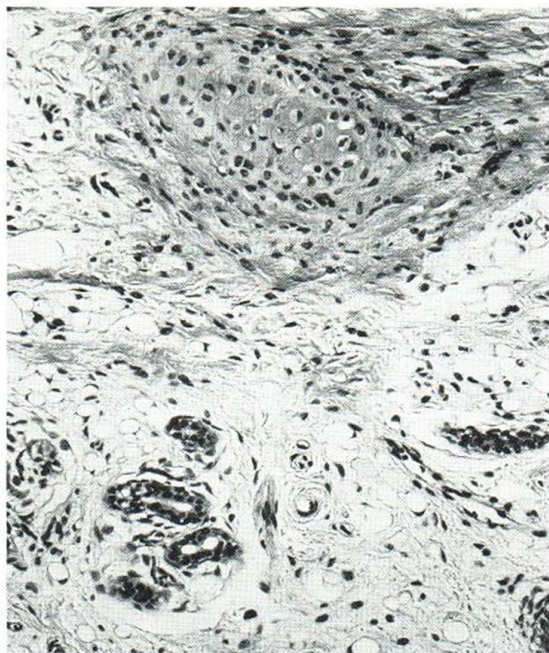


Fig. 2. Cartilaginous tissue in the deep portion of the dermis (hematoxylin-eosin, $\times 200$).

DISCUSSION

Cartilaginous nevus is regarded as arising from the abnormal development of the auricular tubercles or from the tissues surrounding the second, third and fourth branchial clefts (2). Major features of the facial structure are established until the end of the second month of the embryonic life (1) and the most frequent location of cartilaginous nevus is the line of junction of the first and second pharyngeal arches. Less frequently it occurs in the line of junction of the maxillary and mandibular processes, i.e. on the cheek between the auricle and the angle of the mouth (3). Therefore, our case is peculiar because of its location and we were unable to find a similar case in the literature.

Since the facial musculature arises from the first pharyngeal arch (1), we think that the cartilaginous tissue found in the glabella in the present case was a remnant of the branchial cartilage that is derived from the first pharyngeal arch at the time of the differentiation of the facial muscles.

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A Novel Wax Stick Preparation of Anthralin¹

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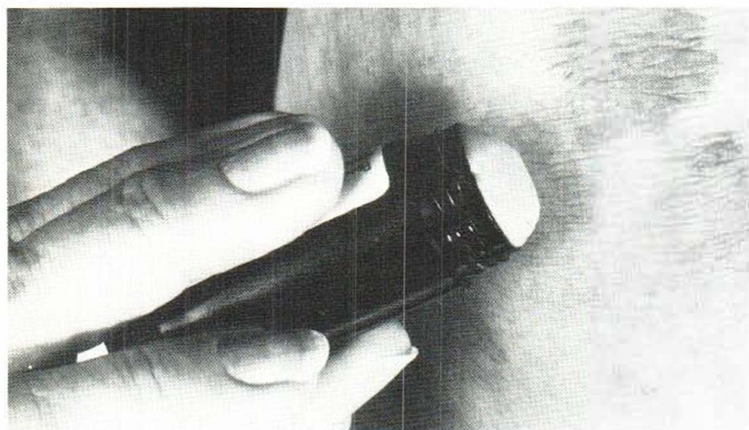
Abstract. A new wax formulation of anthralin was compared with anthralin as used in the Ingram regimen for the treatment of chronic discoid psoriasis. In 16 out-patients 12 of the 13 who responded to the Ingram regimen also showed a satisfactory response to the wax preparation. The latter could be applied more rapidly and simply and may thus have a useful place in the domestic management of chronic psoriasis.

Key words: Anthralin; Chronic psoriasis; Home use

Anthralin is the major active component of the Ingram regimen (2) now widely used for the topical treatment of chronic psoriasis. Used as it is in stiff Lassar's paste it is both messy and time-consuming to apply and must be removed after each treatment. Few patients are able to use the paste successfully at home and several attempts have been made to produce an anthralin application suitable for home use (1, 3). A recent introduction is a wax preparation of anthralin which is held like lipstick in a retractable container for ease of application (see illustration). The wax sticks contain 0.5%, 1% or 2% anthralin with salicylic acid as a stabilizer.

We have carried out small pilot studies in out-patients and in in-patients to compare the new preparation with anthralin in Lassar's paste.

¹ Anthraderm, pHarma-medica; Antraderm, Brocades Ltd.

*Fig. 1*

PATIENTS AND METHODS

16 patients attending the out-patient department for treatment of chronic psoriasis with the Ingram regimen were studied. Before treatment was started one or more test plaques and a comparable control site were chosen. Anthralin wax was applied five times weekly to the test plaques and to the remainder of the affected skin. Patients received tar baths and ultra-violet irradiation as usual in the Ingram regimen. Anthralin wax 0.5% was used for the first two applications, but thereafter higher concentrations were used, if tolerated. Experienced nursing staff selected the concentrations to be used on the control plaques, usually the same as those used for the remainder of the affected skin. Patients were reviewed once a week and at the end of treatment by a single observer to whom they were asked to report any adverse reactions. Five in-patients in whom the previous response to anthralin had been poor were studied in the same manner, except that the treatments were applied every day.

RESULTS

10 of the 16 out-patients responded completely both to the anthralin wax and to the anthralin in Lassar's paste, although the time to remission was slightly but not significantly longer with the former (mean $\pm$ SEM = 3.7 ± 0.3 weeks) than with the latter (mean $\pm$ SEM = 3.3 ± 0.4 weeks). In 2 patients the test sites were virtually clear by 1.6 and 2.4 weeks, when they defaulted from follow-up; one patient responded well to anthralin paste but showed only a minimal response to anthralin wax; 2 patients did not respond to anthralin in either formulation. The 2% formulation of anthralin wax was tolerated by all patients except one who was also intolerant of anthralin in Lassar's paste.

Only one of the 5 in-patients responded to

anthralin paste but her response to the anthralin wax was minimal. One patient was intolerant of anthralin in Lassar's paste but responded to the anthralin wax. In the remaining 3 there was no response to either preparation.

COMMENTS

The anthralin wax was well tolerated, caused less staining than anthralin in Lassar's paste and proved simple and rapid to apply. A preparation with a higher concentration of anthralin would probably have been tolerated by some patients and might have reduced the time required to achieve clearance. Despite the high concentrations of anthralin in the wax the absolute amounts of anthralin applied to the skin may not be dissimilar from those when using much lower concentrations of anthralin in Lassar's paste, since only a thin film of wax is required. If the wax sticks compare well in cost with other currently available proprietary anthralin preparations and if their shelf-life is the 2 years suggested by the manufacturer, then they are likely to prove useful for the domestic management of chronic discoid psoriasis.

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