

Reviewed by Dr. H. F. Ho, Dr. T. Y. Ho, and Dr. W. S. Lam

## **Natural course of physical and chronic urticaria and angioedema in 220 patients**

Kozel MMA, Mekkes JR, Bossuyt PMM, Bos JD.

*J Am Acad Dermatol* 2001;45:387-91.

A prospective cohort study was conducted on 220 consecutive patients with urticaria at a tertiary referral centre in Amsterdam to investigate its natural course. All patients were older than 15 years of age and had urticaria and/or angioedema for at least six weeks. Their mean age was 38 years (range, 15-79). One hundred and thirty-two patients were female. A diagnostic protocol comprising a detailed questionnaire, physical examination, laboratory investigations were administered. Provocation tests were performed when indicated. Thirty-six percent of the patients (n=78) had chronic idiopathic urticaria and/or angioedema, 33.2% (n=73) had physical urticaria, whereas 10.9% (n=24) had both. The rest were related to food, drugs, infections, etc.

The mean follow-up period was two years and four months (range, 12-71 months). Overall 35% of the patients were clear of symptoms after one year. A decrease in symptoms occurred in 28.9%. Spontaneous remission occurred in only 16.4% of patients with physical urticaria (12 out of 73) whereas 47.4% of patients with idiopathic urticaria and/or angioedema were asymptomatic after one year (37 out of 78).

This study had two limitations: firstly, results obtained in a tertiary referral centre might not be extrapolated to other settings; secondly, the patient number in each urticaria subgroup was relatively small.

## **Perianal and genital basal cell carcinoma: a clinicopathologic review of 51 cases**

Gibson GE, Ahmed I.

*J Am Acad Dermatol* 2001;45:68-71.

A retrospective analysis of all perianal and genital basal cell carcinoma (BCC) diagnosed at the Mayo Clinic was undertaken, excluding those due to basal cell nevus syndrome, for the period January 1985 to September 1996.

During the study period, 18943 BCC were diagnosed, of which 51 BCC (0.27%) from 47 patients were at the perianal (n=15) or genital (n=36) areas. Their mean age was 73 years (range, 45-100). Twenty were male. Nine perianal BCC developed in male and six in female. For the genital BCC, 10 were located at the pubic area, 18 at the vulva, six at the scrotum and two

on the penis. Three patients had two BCC. The mean size of tumor was 1.95 cm (range, 0.5-5.2 cm) and 15 (29.4%) were ulcerated. Seventeen patients (36%) had a history of non-melanoma skin cancer on exposed areas. Some had previous pelvic radiotherapy (n=4), chronic vulvar pruritis (n=2) or immunosuppressive treatment (n=2). Human papillomavirus was absent on the five BCC specimens tested. Pathologic subtypes comprised: nodular (66%), superficial (18%), infiltrative (8%), micronodular (4%), basosquamous (2%) and fibroepithelioma of Pinkus (2%). Management comprised wide excision, electrodesiccation and curettage, Mohs surgery and CO<sub>2</sub> laser. One recurrence case without metastasis was noted seven years after wide excision.

The authors highlighted that, despite its rarity, BCC need to be considered in the differential diagnosis of perianal/genital papules, especially in the older age group.

## **Juvenile dermatomyositis: a retrospective review of a 30-year experience**

Peloro TM, Miller III OF, Hahn TF, Newman ED.

*J Am Acad Dermatol* 2001;45:28-34.

A retrospective review of all patients with juvenile dermatomyositis (JDM) from 1968 to 1998 at the authors' institution was undertaken.

Sixteen patients were identified, female-to-male ratio being 1.7:1. Their mean age was 7.8±0.9 years (range, 3-14). Thirty one percent of patients presented initially with arthralgia and myalgia, 25% with weakness, 25% with a "rash" and 19% with both weakness and a "rash". An extremity rash (94%) and periungual erythema (75%) were the commonest initial physical findings. The former was characterized by erythematous scaly plaques over the extensor aspect of elbows and knees. The heliotrope rash and Gottron papules were less common. Other notable features included pruritis (38%) and a scalp psoriasiform dermatitis (25%). Elevation of creatine kinase (60%) and aldolase (31%), though considered specific, might be delayed. Tubuloreticular inclusions were found on electron microscopy (EM) of all three muscle biopsy specimens. One was from an otherwise normal biopsy on routine staining, thus supporting the use of EM in difficult case.

The authors concluded that an extremity rash, periungual erythema, pruritis, a scalp psoriasiform dermatitis and tubuloreticular inclusions on EM of

muscle biopsy were important diagnostic features to look for. Also serial testing was sometimes necessary to detect elevation in muscle enzymes.

### **Low dose cyclosporin A treatment in generalized pustular psoriasis**

Kulic SS, Hacimustafaoglu M, Celebi S, Karadeniz A, Ildirim I.

*Ped Dermatol* 2001;18:246-8.

Low dose (1-2 mg/kg/day) cyclosporin A (CSA) was used in three young patients with generalized pustular psoriasis, a condition difficult to manage in childhood. Control was satisfactory: complete control was achieved in two to four weeks in all three patients. No side effects were reported.

The first patient was a girl, age six at presentation. She had generalized pustular psoriasis since three months old and failed methotrexate, systemic steroid and topical treatments. CSA was given for 12 months and she had no flare up for three years.

The second patient was the 10-month-old brother of the first patient. He suffered from the disease since the age of two months. CSA was given for a total of six months. He was still in remission in the second year of follow-up.

The third patient was a 17-month boy with generalized pustular psoriasis at birth. He failed to respond to topical steroids and was started on low dose CSA with good response. He was still receiving the medicine after five months without significant side effects.

The authors concluded that cyclosporin A used in short courses might be a useful treatment for generalized pustular psoriasis in children.

### **Double-blind placebo-controlled house dust mite control measures in adult patients with atopic dermatitis**

Gutgesell C, Heise S, Seubert S, et al.

*Br J Dermatol* 2001;145:70-4.

The evidence regarding the effect of house dust mite elimination and improvement of atopic dermatitis are conflicting. This authors undertook a randomized controlled study of the effect of house dust mite control on adult atopic dermatitis. Twenty patients, age 18-30 with moderate to severe atopic dermatitis were recruited.

They all have a positive RAST to house dust mite antigen (CAP class >3) plus house dust mite antigen Der p1 concentration >2 µg/g in mattress dust. In the treatment group, they used allergen-impermeable encasing and an acaricide spray. In the control group, they used placebo material. In this one-year study, severity was assessed using SCORAD, eosinophil cationic protein in serum, consumption of topical steroids and patient self-assessed score for pruritus and pruritus-induced sleeplessness.

While there was a statistically significant decrease in exposure to house dust mite antigens in the treatment group, difference in control of atopic dermatitis between the treatment and control groups was not statistically significant. The authors concluded that in adults with atopic dermatitis, although measures to reduce mite antigens were effective, an improvement of disease control was not observed.

### **Photodynamic therapy with meta-tetrahydroxyphenylchorin for basal cell carcinoma: a phase I/II study**

Baas P, Saarnak AE, Oppelaar H, Neering H, Stewart FA.

*Br J Dermatol* 2001;145:75-8.

Photodynamic therapy (PDT) is a new treatment for basal cell carcinoma (BCC). It is especially useful for patients with multiple lesions and with lesions on the face. The established PDT employed haemato-porphyrin derivative (HPD) or aminolaevulinic acid (ALA), but their use were hampered by protracted photosensitivity (eight weeks), unacceptably long exposure time (10-40 minutes per lesion) and limited depth of penetration. A second-generation photosensitizer, meta-tetrahydroxyphenylchorin (mTHPC) was studied in this trial.

The authors tried to delineate the appropriate regimen for mTHPC PDT. The light source was a light-emitting diode system with 652 nm output. mTHPC (0.10 mg/kg) was given intravenously. Five patients with multiple BCC (12-200 lesions each) were recruited and totally 187 treatments were given. Doses of 5, 10, 15 J/cm<sup>2</sup> were given on randomly chosen lesions (about three sites per patient per day for each dose) on day 1, 2, 3 or 4 following mTHPC administration. They found that a dose of 10 or 15 J/cm<sup>2</sup> with exposure on day 1 or 2 gave the best result. The complete remission rate was 78-86% at one year. Photosensitivity lasted for two weeks. The authors concluded that PDT with mTHPC was a promising treatment modality for BCC.

### **Systemic lupus erythematosus presenting with oral mucosal lesions: easily missed?**

Orteu CH, Buchanan JAG, Hutchison I, Leigh IM, Bull RH.

*Br J Dermatol 2001;144:1219-23.*

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This paper described two patients with oral mucosal lesions as the first presentation of systemic lupus erythematosus (SLE) and reviewed such manifestations in SLE.

A wide variety of oral mucosal lesions was described in lupus erythematosus (LE): cheilitis, erythematous patches, discoid lesions, lichen planus (LP)-like lesions, honeycomb plaques and ulcers. Nine to 45% of LE patients were reported to have these lesions.

These oral lesions were usually chronic and sometimes asymptomatic. Affected patients often presented late to their doctors and not uncommonly until other skin or systemic symptoms arose. Oral lesions as the first feature of SLE might not be uncommon. In a prospective study, oral lesions were found to be the first sign of lupus in 40% of SLE patients. Patients with discoid LE, oral lesions and a high titre of antinuclear antibodies had a higher risk of developing SLE. Differentiating between LP and oral mucosal LE could be difficult. Direct immunofluorescence might find immunodeposits in LE but only rarely in LP. Treatment was symptomatic. Antimalarials and azathioprine were the agents used by the authors. Other alternatives were methotrexate, dapsone and gold. The authors concluded that LE should be considered in the differential diagnosis of oral mucosal lesions.

### **Mycophenolate mofetil is effective in the treatment of atopic dermatitis**

Grundmann-Kollmann M, Poddar M, Ochsendorf F, Boehncke W, Kaufmann R, Zollner TM.

*Arch Dermatol 2001;137:870-3.*

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Mycophenolate mofetil is a new immunosuppressant approved for the treatment of acute renal graft rejection. It is rapidly absorbed orally and is hydrolysed to mycophenolic acid, which can inhibit the de novo synthesis of purine in T and B cells, leucocyte recruitment and glycosylation of lymphocytic adhesion glycoproteins.

This pilot study demonstrated the effectiveness of mycophenolate mofetil in the treatment of moderate-to-severe atopic dermatitis. Ten adult patients with

moderate-to-severe atopic dermatitis who had not responded to conventional topical and systemic treatment were treated with mycophenolate mofetil one gram twice daily for four weeks followed by 500 milligram twice daily for four weeks. The severity of atopic dermatitis was assessed using the subjective SCORAD index.

Significant improvement was recorded in all patients within four weeks of treatment, the mean SCORAD index decreased from  $49.2 \pm 13.8$  to  $27.5 \pm 11.7$ . Seven patients cleared completely after four weeks, with the remission being long-lasting in six during a 20-week follow-up. Two patients responded initially but relapsed after five to six weeks of treatment. Mycophenolate had to be stopped in one patient after four weeks due to the development of herpes retinitis. No adverse effects were observed in other subjects.

### **The risk of malignancy associated with psoriasis**

Margolis D, Bilker W, Hennessy S, Vittorio C, Santana J, Strom BL.

*Arch Dermatol 2001;137:778-83.*

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This is a retrospective cohort study using data from the Medicaid programs of three states in the United States from 1992 to 1996. The incidence of malignancy was calculated for individuals in the following five groups: (1) severe psoriasis, defined as psoriasis treated with one or more systemic therapies (n=1,101); (2) less severe psoriasis, defined as psoriasis not treated with any systemic therapies (n=16,519); (3) severe eczema (n=3,869); (4) transplant patients on immunosuppressants (n=4,015); and (5) essential hypertension (n=234,304).

Compared to the hypertension group which served as control, patients with severe psoriasis and transplant patients had a higher chance of developing a malignancy (adjusted relative risk: 1.78 and 2.12, respectively). The risk was only slightly increased in patients with less severe psoriasis (adjusted relative risk=1.13), and was comparable to that for patients with eczema (adjusted relative risk=1.04). Most of the increased cancer risk for patients with psoriasis was attributed to lymphoma and non-melanoma skin cancers.

This study confirmed the increased risk of malignancy in patients with severe psoriasis on systemic treatment. However, it could not be ascertained whether the increased risk was due to drug use or due to severe psoriasis itself.

**Defined UV protection by apparel textiles**

Hoffman K, Laperre J, Avermaete, Altmeyer P, Gambichler T.

*Arch Dermatol* 2001;137:1089-94.

This review article discussed the test methods, standardization and the various factors affecting the ultraviolet (UV) protective effect of clothing.

According to the Australian/New Zealand Standard (AS/NZS), the UV protection of a fabric is measured by the UV protection factor (UPF). Analogous to the sun protection factor (SPF) of sunscreens, UPF reflects the protection against the erythemogenic effect of the sun, which is mostly caused by UVB. Transmission of UVA through fabrics is usually less than 5%. In Europe, only textiles with UPFs of 30 or more may be labelled as sun protective.

Not all clothing provides adequate protection against the sun. Summer fabrics such as cotton (especially bleached), viscose, rayon and linen offer relatively low UV protection as compared with nylon, wool, and silk. Polyester has high UPF but is relatively permeable to UVA. UV protection is also dependent on the porosity of the fabric (tightness of weave), dyeing (dark colours usually provide better protection), stretch, and wetness (reduced UPF for cotton, cotton/polyester, polyamide/elastane, increased UPF for viscose and silk when wet). Recently, UV absorbers for pre-treating fabrics and for laundry products have been developed. These can enhance the protective effect of clothing.

**Incidence of cancer among patients with hidradenitis suppurativa**

Lapins J, Ye W, Nyren O, Emtestam L.

*Arch Dermatol* 2001;137:730-4.

This retrospective cohort study was carried out to investigate the possible increased risk of cancer in patients with hidradenitis suppurativa (HS) using data from the Inpatient Register of the National Board of Health and Welfare (from 1965 to 1997) and the Register of the Causes of Death in Sweden.

A total of 2,119 patients with HS were followed up for an average of 9.8 years (total patient-years at risk: 20,801). Compared with the age- and sex-matched general Swedish population, the risk for all cancers was increased by 50% in the cohort group. Statistically significant increased relative risks were observed for the following: non-melanoma skin cancer, buccal cancer and primary liver cancer.

The authors speculated that the increased risk of skin cancers was due to the long standing irritation and infection involved in the pathological process of HS. The mechanism for the increased risk of buccal cancer and liver cancer was unknown, as information on the drinking and smoking habits of the cohort was not available. The authors also acknowledged the limitation that the cohort consisting of selected HS patients, namely those who had been admitted into hospital.

**Porphyria cutanea tarda and melioidosis**

Fung WK, Tam SCF, Ho KM, Lam P, Lo KK.

*Hong Kong Med J* 2001;7:197-200.

The authors reported the development of porphyria cutanea tarda (PCT) in a 64-year-old Chinese woman with one-year history of pulmonary melioidosis. The diagnosis of melioidosis was confirmed by *Burkholderia pseudomallei* serology. After taking doxycycline and co-amoxiclav for six months, she presented with itchy vesicles and skin fragility on extensor surface of forearms and hands. Skin biopsy and porphyrin analysis confirmed a diagnosis of PCT. The serum ferritin was increased. The rash persisted despite sunscreen use and venesection monthly for three months. Discontinuation of the antibiotics resulted in resolution of the rash. This temporal sequence supported a triggering role of the antibiotics for PCT in the patient. Also iron overload might act as a precipitating factor for PCT, although the cause of excess iron was unknown. Similar to the effects of hepatotropic viruses or alcohol, bacterial infections like melioidosis might cause liver damage, aggravating the hepatotoxic effects of iron.

This was the first reported PCT case associated with melioidosis. Coincidental occurrence was unlikely because both PCT and melioidosis were rare in Hong Kong.