

## Journal Watch

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### **Vulvar syringoma: a clinico-pathologic and immunohistologic study of 18 patients and results of treatment**

Huang YH, Chuang YH, Kuo TT, Yang LC, Hong HS.  
*J Am Acad Dermatol* 2003;48:735-9.

The authors analysed 18 patients with vulvar syringoma diagnosed in a Taiwan hospital over the past ten years. The median age of first presentation was 29.5 years (range: 21-60). Thirteen patients (72%) had pruritus vulvae, with seven of them having exacerbation of pruritus during menstruation or summer period. Most (61%) presented with multiple flesh-coloured or brownish papules on labia majora. Some (17%) had discrete whitish cystic lesions while some (22%) had itchy lichenoid plaques. Six patients (33%) also had associated periorbital syringoma and, among them, four had a family history of extragenital syringoma. All cases were confirmed histopathologically. Sweat duct-like glandular structures and solid epithelial nests in a sclerosing background were noted. Immunohistochemical study was undertaken to look for progesterone receptor and oestrogen receptor in fifteen patients. The staining for the receptors was negative in all the specimens tested.

Oral antihistamines and topical steroids were given to fourteen patients, but without any response. For seven patients with intractable itch, carbon dioxide laser was tried with resolution of the lesions and symptoms.

The authors suggested that vulvar syringoma was not rare and should be entered into the differential

diagnoses of pruritus vulvae. Carbon dioxide laser ablation was effective in their patients with intractable pruritus.

### **Efficacy and safety of desloratadine 5 mg once daily in the treatment of chronic idiopathic urticaria: a double-blind, randomised, placebo-controlled trial**

Monroe E, Finn A, Patel P, Guerrero R, Ratner P, Bernstein D, et al.  
*J Am Acad Dermatol* 2003;48:535-41.

The effectiveness and safety of desloratadine, a new H<sub>1</sub>-receptor antagonist, in treating chronic idiopathic urticaria (CIU) were assessed in a multi-centre, randomised, double-blind, placebo-controlled study.

The prospective subjects had to undergo a screening phase, during which, inclusion and exclusion criteria were considered and their disease severity determined. Their overall CIU severity had to be at least moderate before acceptance into the trial. A total of 226 patients were recruited, with 116 randomly allocated to receive desloratadine 5 mg once daily and 110 to receive placebo. They were treated for six weeks, with efficacy and safety measures taken regularly.

Desloratadine-treated patients showed greater improvement of their total CIU symptom score when compared with their placebo-treated counterparts. The reduction in the score for

pruritus, number of hives and size of largest hive were better with desloratadine. Interference with sleep and daily activities by CIU were also ameliorated to a greater extent in the desloratadine-treated group. Joint patient-investigator assessment of overall CIU status and therapeutic response found that desloratadine was significantly better than placebo. Significant benefits were noted within the first 24 hours of desloratadine treatment and its efficacy was maintained for the study duration. There was no significant difference in the adverse events between the desloratadine-treated and placebo-treated group. More specifically, no significant ECG changes were noted in the desloratadine-treated patients, compared with baseline.

The authors concluded that desloratadine was a safe and effective medication for CIU. The study was supported by a grant from the Schering-Plough Research Institute.

### **Tacrolimus ointment for the treatment of psoriasis on the face and intertriginous areas**

Freeman AK, Linowski GJ, Brady C, Lind L, Vanveldhuisen P, Singer G, et al.  
J Am Acad Dermatol 2003;48:564-8.

The effectiveness and safety of 0.1% tacrolimus ointment in treating psoriasis on face and intertriginous areas were assessed in an open uncontrolled study.

Twenty-one patients (15 males, 6 females) were recruited and completed the study. Their mean age was 48 years (range: 22-86). The degree of erythema, infiltration and desquamation at the treatment sites were rated numerically through physician's assessment. They all had moderate disease severity before treatment. The overall change in post-treatment disease severity was also evaluated. Progressive improvement in the cutaneous signs was noted as early as day 8 of

treatment. At day 57 (end of trial), all signs showed statistically significant improvement compared with baseline ( $P < 0.0001$ ). Five patients (23.8%) showed complete clearance and 10 patients (47.6%) showed marked (more than 75%) clearance by day 8 of treatment. By day 57, 17 patients (81.0%) were completely cleared and the remaining four patients had marked clearance. Two patients had side effect: one had a local warm sensation while the other had increase itching at the treatment site. Both events were mild and transient. No signs of skin atrophy were noted.

The authors suggested that 0.1% tacrolimus ointment might be a safe and effective medication for treating facial and intertriginous psoriasis. The study was supported by Fujisawa Healthcare Incorporated. Further randomised double-blind controlled trials were necessary to confirm the favourable results, perhaps also comparing the medication with topical corticosteroids. A drug-free follow-up period is also worthwhile to see how long the remission will last.

### **The new 940-nanometer diode laser: an effective treatment for leg venulectasia**

Passeron T, Olivier V, Duteil L, Desruelles F, Fontas E, Ortonne JP.  
J Am Acad Dermatol 2003;48:768-74.

This study evaluated the efficacy of the 940-nm diode laser without cooling on leg telangiectases. Totally 60 patients were enrolled. Their mean age was 44.4 years (range: 25-75) and 58 were women. Their skin types were I to IV. They received up to three treatment sessions at 4-week intervals. The treatment parameters were selected according to the vessel size. For telangiectases less than 0.4 mm in diameter, the parameters were: 0.5 mm spot size, 10 milliseconds pulse duration, fluence 306 J/cm<sup>2</sup>. For those 0.4-0.8 mm in diameter, the setting were 1 mm spot size, 30 milliseconds pulse duration, fluence 306 J/cm<sup>2</sup>. For those 0.8-

1.4 mm in diameter, the settings were 1.5 mm spot size, 70 milliseconds pulse duration, fluence 317 J/cm<sup>2</sup>. The aim was to cause complete vessel disappearance without epidermal blanching. Blinded photographic assessments were made.

Fifty-two patients completed the study. Six patients dropped out for pain intolerance and two discontinued after one session for lack of improvement. For telangiectases less than 0.4 mm in diameter, only 13.33% had more than 75% vessel clearance. For those 0.4-0.8 mm in diameter, 39.29% had more than 75% vessel clearance. However, for those 0.8-1.4 mm in diameter, 88.24% had more than 75% vessel clearance, with 35.3% having complete clearance. The most important adverse effect was pain. Others included mild erythema, crusting (35%), and hypopigmentation (6.7%).

Thus the success of the 940-nm diode laser in leg telangiectases was vessel-size dependent, with better results in those 0.8-1.4 mm in diameter. Cooling technology may help to decrease pain and epidermal disruption.

### **Analysis of patients with suspected photosensitivity referred for investigation to an Australian photodermatology clinic**

Crouch RB, Foley PA, Baker CS.

*J Am Acad Dermatol* 2003;48:714-20.

The authors reported the experience of the first photodermatology clinic in Australia from April 1993 to October 2000. Totally 513 patients (289 females and 224 males) were seen during this period. Their mean age was 45.2 years. Most patients (77.4%) were diagnosed to have a photosensitive disorder. Acquired idiopathic photodermatoses constituted the largest group and was found in 215 patients (41.9%). Polymorphous light eruption was the commonest

diagnosis and was seen in 118 patients (23.0%). Monochromator light testing was done in 368 patients, with reduced minimal erythema dose seen in 93 patients (25.3%) at 24 hours. Chronic actinic dermatitis was the most important disease among those with abnormal phototest responses and was noted in 34 out of the 93 patients (36.6%). Patch and photopatch testing was performed in 172 patients. There was at least one contact, photocontact, or combined reaction in 117 patients (68%). However, allergic contact dermatitis was the primary diagnosis in 38 patients (7.4%) and photoallergic contact dermatitis the primary diagnosis in seven (1.4%) only. Fragrance constituents was the commonest patch-test allergen (36.6%) and perfume mix the commonest photopatch-test allergen (8.7%) among the 117 patients with at least one positive reaction. These might be related to the high-volume use of fragrances in Australia.

The authors suggested that a dedicated photodermatology clinic was able to confirm photosensitivity, delineate an accurate diagnosis and allow development of expertise in photomedicine.

### **Calcitriol vs dithranol in combination with narrow-band ultraviolet B (311 nm) in psoriasis**

Hofmann UB, Eggert AA, Brocker EB, Goebeler M. *Br J Dermatol* 2003;148:779-83.

This study compared the efficacy of narrow-band UVB (311 nm) plus dithranol versus its combination with topical calcitriol in the treatment of psoriasis. Ten hospitalised patients (four males and six females, mean age 41 years) with symmetrical plaque-type or guttate psoriasis involving at least 10% body surface area were recruited. Patients were excluded if acitretin, methotrexate, immunosuppressants or phototherapy were given within the past six months. Patients were assigned to apply calcitriol ointment

3 µg/g twice daily to the affected skin of the right or left arm according to their birth year. Topical dithranol supplemented with salicylic acid (2%) was applied to the rest of the body every evening for 12 hours. Depending on skin phototypes, narrow-band UVB starting from 0.2 to 0.4 J/cm<sup>2</sup> was delivered five times a week and its dosage was gradually increased to a maximum of 2.5 J/cm<sup>2</sup>. Patients were assessed using a modified PASI score and a questionnaire on quality of life.

Both combinations were found to be equally effective and complete clearance was achieved after a mean of four weeks. Statistical analysis showed no significant differences in terms of the reduction of the modified PASI score at any time. Some patients preferred calcitriol as it caused less irritation.

The authors suggested that combination therapy of narrow-band UVB with calcitriol was as effective as the combination with dithranol in treating psoriasis. However, the small number of patients is a major drawback in this study. Other defects include the lack of blinding and asymmetrical application of the two medications on the subjects.

### **Narrowband UV-B (TL-01) phototherapy vs oral 8-methoxypsoralen psoralen-UV-A for the treatment of chronic plaque psoriasis**

Markham T, Rogers S, Collins P.  
Arch Dermatol 2003;139:325-8.

This was an open, randomised trial comparing narrowband UVB (NB-UVB) given three times weekly, with oral psoralen-UVA (PUVA) phototherapy twice weekly, in the treatment of chronic plaque psoriasis. Patients studied were of skin types I, II and III.

Fifty-four patients (30 men, 24 women) were studied, of which 29 received NB-UVB and 25

received PUVA. Forty-five patients completed the study. Three patients flared during treatment (NB-UVB: one, PUVA: two) and were withdrawn. The number of PUVA treatments required to achieve clearance was significantly lower than that for NB-UVB (19.0 vs. 25.5,  $p=0.03$ ), but there was no significant difference in the number of days in treatment and the duration of remission. There was no significant difference between the two treatments in patients with extensive (PASI score  $\geq 14$ ) or localised disease (PASI score  $< 14$ ) in terms of the number of treatments required or duration of remission. A similar proportion of patients developed grade I erythema with both treatments (NB-UVB: 75%, PUVA: 80%). Polymorphic light eruption and pruritus affected both groups equally, but nausea and grade 2 erythema were seen only with PUVA. No other side effects were reported.

The findings of this study suggest that PUVA and NB-UVB are equally effective in treating chronic plaque psoriasis. However, the majority of our local population has skin type IV or above, and whether these findings can be extrapolated to our locality is unclear. In addition, data on the long-term risk of skin malignancy with NB-UVB is still pending.

### **Clinical risk factors for mortality in patients with neurofibromatosis 1: a cohort study of 378 patients**

Khosrotehrani K, Bastuji-Garin S, Zeller J, Revuz J, Wolkenstein P.  
Arch Dermatol 2003;139:187-91.

A cohort study of 378 patients with neurofibromatosis 1 (NF-1) who had over one year follow-up at a French referral centre for neurofibromatosis was performed. Clinical features as potential risk factors associated with mortality were studied. In particular, the following cutaneous signs were noted: number of café au lait spots, number of cutaneous and subcutaneous neurofibromas, and flexural freckling.

Of the 378 cases, there were 166 males and 212 females with a mean age of 32.7 years (range: 7-75 years). They were followed up for a median duration of 53.1 months (range: 12-72 months). Eleven patients died during the follow-up period of the following causes: astrocytoma (n=1), carcinoid tumour (n=1), malignant peripheral nerve sheath tumour (n=6), and spinal cord compression (n=3).

The number of café au lait spots decreased significantly with age while the number of cutaneous neurofibromas increased with age. However, there was no correlation between the number of subcutaneous neurofibromas and age. Also mortality was not associated with age. By multivariate analysis, the presence of two or more subcutaneous neurofibromas was associated with mortality (odds ratio 10.8, 95% confidence interval 2.1-56.7). The absence of cutaneous neurofibromas (odds ratio 5.3, 95% confidence interval 1.2-25.0) and facial asymmetry (odds ratio 11.4, 95% confidence interval 2.6-50.2) were also independently associated with increased mortality.

This study identified some clinical features associated with mortality in NF-1. The authors suggested that affected patients should be targeted for follow-up. Nevertheless, whether these findings can be extrapolated to patients of oriental origin is not known.

### **Defining the clinical course of metastatic skin cancer in organ transplant recipients: a multicentre collaborative study**

Martinez JC, Otley CC, Stasko T, Euvrard S, Brown C, Schanbacher CF, et al.

Arch Dermatol 2003;139:301-6.

The clinical course of metastatic skin malignancy in organ transplant recipients

was studied. There were 68 patients (60 males and 8 females) with 73 separated metastatic events. All patients were taking immunosuppressive therapy to prevent rejection.

Their mean age at transplantation was 44.3 years. Renal transplant patients formed the majority (78%). Squamous cell carcinoma was the commonest primary tumour (85%), followed by Merkel cell carcinoma, melanoma and others. The site of the primary tumour was unknown in 27% cases, mostly due to multiple possible primary tumours. Otherwise most occurred on the head and neck region (53%). Nodal involvement occurred in 78% of patients and was more common than systemic spread (35%). In-transit metastases were noted in 26% of patients. Thirty-nine patients (57.4%) had metastases at one site, while 16 (23.5%) had two sites affected. The mean time from transplantation to diagnosis of primary tumour was 8.8 years (range: 1.1-26.9 years), while the mean time from primary tumour to diagnosis of metastases was 1.4 years (range: 0-8.3 years).

After treatment, 29% patients with metastases relapsed by one year. Twenty-three (34%) patients died from metastatic disease while 11 died from other causes. The 3-year disease-specific survival after diagnosis of metastasis was 56%. There was no significant difference between surgical and non-surgical treatment of metastases in terms of disease-specific survival. Patients who presented with systemic or distant metastases had a poorer prognosis than those with regional or in-transit disease.

The authors concluded that metastatic skin malignancy in organ transplant patients had a poor prognosis and detection at an early stage might help to improve survival.

### **Topical nitrogen mustard in the management of mycosis fungoides: update of the Stanford experience**

Kim YH, Martinez G, Varghese A, Hoppe RT.  
Arch Dermatol 2003;139:165-73.

The response of 203 patients with mycosis fungoides (clinical stage I-III) treated with topical nitrogen mustard (10-20 mg/100 ml) as initial therapy was assessed in this retrospective study. Patients who had received other preceding or concurrent forms of therapy were excluded.

Their median age was 56 years (range 12-87 years) and male-to-female ratio was 1.6:1. The overall response rate was 83%, complete response (CR) being 50% and partial response 33%. The median time to relapse in patients with CR was 12 months (range 1-60 months). The overall response rate for T1 disease and T2 disease was 93% (CR: 65%) and 72% (CR: 34%) respectively. The relapse rate was not affected by the duration of maintenance treatment. Similar response rates were seen when topical nitrogen mustard was used as salvage therapy. At five and 10 years, the freedom-from-progression rates were 92% and 85% in patients with T1 disease respectively, and both 83% for patients with T2 disease respectively.

Irritation and allergic contact dermatitis were the most common side effects. There was no difference in efficacy between aqueous and ointment preparations, although there was a greater incidence of hypersensitivity reactions with the aqueous one. There was no evidence of systemic absorption in six young patients (<18 years old). Although eight (4%) patients developed skin malignancies, none were related to topical nitrogen mustard therapy.

Thus this study showed that topical nitrogen mustard was a safe and effective therapy for mycosis fungoides patients with T1 and T2 disease.

### **Incidence of cutaneous tuberculosis in patients with organ tuberculosis**

Kivanc-Altunay I, Baysal Z, Ekmekci TR, Koslu A.  
Int J Dermatol 2003;42:197-200.

The authors investigated the relationship between organ tuberculosis (TB) and cutaneous TB. Between 1996 and 1998, 370 hospital patients (225 males and 145 females, mean age 27.5) with documented pulmonary or extra-pulmonary TB were screened for signs of cutaneous TB. Skin biopsies were taken if cutaneous lesions were present.

There were 347 cases of pulmonary TB and 23 cases of extra-pulmonary TB, including nine cases of TB adenitis, six cases of TB peritonitis, three cases of bone TB and five cases of TB meningitis. Only 13 (3.51%) patients were found to have cutaneous TB, including eight scrofuloderma, five lupus vulgaris and one BCG adenitis. One patient had both scrofuloderma and lupus vulgaris concomitantly. Tuberculids were not detected and that might be due to the fact that all these patients had already been given anti-tuberculosis therapy. The most frequent organ TB causing cutaneous TB was TB adenitis (44.4%, four out of nine patients, mostly as scrofuloderma). Cutaneous TB was not found in miliary TB, bone TB, TB peritonitis and meningitis. There were more females with cutaneous TB than males (4.82% versus 2.6%). The mean age of the patients was younger with scrofuloderma (24.8 years) than lupus vulgaris (48.0 years). Also lupus vulgaris appeared to develop in patients with pulmonary TB of a longer duration, compared with those with scrofuloderma.

The authors suggested that cutaneous involvement was uncommon among hospital patients under treatment for organ tuberculosis. This study gives a regional perspective on the relationship between cutaneous and organ TB. Selection bias might operate as only hospital patients were recruited.

### **Lichen planopilaris: report of 30 cases and review of the literature**

Chieriegato C, Zini A, Barba A, Magnanini M, Rosina P.

Int J Dermatol 2003;42:342-5.

This Italian study reviewed 30 cases of histologically proven lichen planopilaris diagnosed between 1996 and 2001. There were 21 females and nine males with a mean age of 51.5 years. The duration of disease varied from one to 48 months (mean, 13 months). All had scalp involvement. Six patients had additional cutaneous involvement, three had nail involvement, and two had oral mucosal involvement. Size of lesions ranged from a few centimetres in diameter to involvement of the whole vertex. All were negative for antinuclear antibodies, antibodies to extractable nuclear antigens, and HbsAg. One case of hepatitis C was detected while another was associated with autoimmune hyperthyroidism. Histologically, almost all cases showed a band-

like subepidermal lymphocytic infiltrate and 20% of them showed flattening of the rete ridges with a saw-like appearance. Though direct immunofluorescence was non-specific in 57% of the patients, colloid bodies staining positive for IgM and a junctional band of fibrin were detected in the rest. After treatment with moderately potent topical steroids for 12 weeks, 20 patients (66%) achieved complete resolution of the inflammatory process with cessation of progression of scarring. Six (20%) achieved partial improvement. Four patients (13%) did not respond to topical steroids alone. Two of them improved with systemic cyclosporin A (5 mg/kg/day for 15 days, then 3 mg/kg/day for 30 days) while one achieved clinical remission with topical cyclosporin A.

The study demonstrated that the majority of lichen planopilaris patients responded well to topical steroids alone. Nevertheless their long-term prognosis still awaits further follow-up.

### **Answers to Dermato-venereological Quiz on page 169**

1. The clinical differential diagnoses include erythema annulare centrifugum (EAC), dermatophyte infection, cutaneous lupus erythematosus, mycosis fungoides, urticarial vasculitis, erythema migran, erythema multiforme, and Hansen's disease.
2. Laboratory investigations should include KOH examination for fungus, complete blood count, liver and renal function tests, chest radiography, serum immune markers, stool for parasites. Skin biopsy performed showed superficial perivascular dermatitis pattern with small mounts of parakeratosis, mild epidermal spongiosis and superficial perivascular lymphocytic infiltrate. Correlating with clinical features the most likely diagnosis is superficial type EAC.
3. EAC has been reported to associate with dermatophytosis, candidiasis, blue-cheese ingestion, connective tissue diseases, drugs such as penicillin, ascariasis, hyperthyroidism, hypereosinophilic syndrome, dysproteinaemia and malignant neoplasms. However, most cases of EAC remained unexplained.
4. Underlying causes and possible associations should be excluded. Treatment may not be indicated if it is asymptomatic. Systemic antihistamines, topical steroids and topical calcipotriol may be tried. Systemic steroid and immunomodulatory agents may be indicated in very severe cases.