Severe Idiopathic Recurrent Aphthous Stomatitis: Treatment with Pentoxifylline

Sir,

Some patients with idiopathic recurrent aphthous stomatitis (IRAS) suffer from an intractable and very annoying form of the disease, with new lesions developing before older lesions have healed. In these patients topical therapy is of little value and systemic treatment is indicated (1). Corticosteroids, dapsone, colchicine and thalidomide may suppress disease activity but none of them can produce a cure and all of them are potentially toxic (1). Pentoxifylline (PTX), a drug virtually free of serious side-effects, has been shown to have pronounced anti-inflammatory effects both in vitro (2,3) and in vivo (4,5). It was therefore decided to try to treat patients with severe IRAS with PTX.

Three otherwise healthy young adult males with severe and intractable IRAS were treated with a 1-month course of oral PTX 400.0 mg t.d.s. Disease activity was suppressed and gradual but total healing of all the lesions was observed in each one of the patients. Two of the patients were followed up for 2 years and 9 months after completion of the treatment, and they have had no further recurrences since then. The third patient was lost to follow-up. To the best of knowledge (6), this is the first attempt to treat IRAS with PTX. The clinical impression from this preliminary trial is encouraging, since it seems that PTX does not only have a suppressing effect on disease activity but may also induce long-term remissions. Obviously, additional studies conducted on large numbers of patients are warranted in order to confirm the validity of these findings.

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Plantar Psoriasis: Clinical Correlation of Lesion Pattern to Weight Bearing

Sir,

The soles are not uncommonly involved in psoriasis. Lesions on the soles occur alone or in conjunction with lesions of psoriasis at other sites. The reported incidence of sole involvement varies from 0.4% to 24% of all psoriasis patients (1,2). The lesions are mostly discrete and scattered over the soles, but diffuse involvement may also occur. Sharply defined hyperkeratotic scaly plaques and small hard keratotic lesions with a feel like nail heads are known to occur. Fissuring may be a prominent feature in some cases. Plaques of psoriasis over soles may saddle the borders of the sole, and lesions extending onto the dorsum of the foot are usually characteristic. Triggering factors like trauma in the form of weight bearing may play a role in localising the lesions at a particular site on the sole (3). A patient has been reported in whom lesions of psoriasis developed following athletic activity and the distribution of lesions correlated to the normal weight bearing curve of foot during routine walking (4), highlighting the koebnerisation phenomenon in psoriasis.

We examined, during 2 years, all patients attending the Psoriasis Clinic of the Postgraduate Institute of Medical Education and Research, Chandigarh, India. They were specifically screened for involvement of soles, irrespective of the extent of the disease on other sites. The pattern of lesions over both the soles was recorded diagrammatically for each patient. Patients with involvement of soles as a part of extensive psoriasis, psoriasis erythroderma or pustular psoriasis were excluded from the study. Patients were recruited irrespective of age, sex, duration of disease or occupation (laborers and players included). Most of the patients used to work either barefoot or wore loose sandals/slip on type of shoes. Only some students, office workers and players wore socks and shoes. Diagnosis of plantar psoriasis was mainly clinical.

Of the 921 patients, 182 (19.8%) had involvement of soles (100 men and 73 women) with a mean age of 34.5 years. Lesions were symmetrical in 159 (82%) patients. The instep of the sole either alone 40 (22%) or in association with other areas of the sole 99 (54.4%) was the commonest site involved. Sites of pressure, i.e. heel 5 (3%), forefoot 5 (3%), lateral border 3 (2%) alone or in combination 43 (24%) were the areas next in order of involvement. Diffuse involvement of soles occurred in 16 (9%) and lesions extended onto the dorsum of the foot in 17 (9%) patients. All patients had well defined hyperkeratotic plaques with adherent scales.

Psoriasis is known to appear at sites of local injury, trauma, scar or vaccination, presumably as apart of the koebner phenomenon. Predominant involvement of instep (54.4%) cannot

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be explained on the basis of pressure alone. However, involvement of sites of pressure like heel, lateral border and forefoot can be explained on the basis of koebnerisation. Trauma in the form of normal weight bearing areas of the foot may have a role in determining the sites of localisation of some of the lesions, but the predominant pattern of non-pressure site involvement has to be explained on the basis of factors other than shearing stress.

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Mucosal Hyperpigmentation due to Oxabolone

Sir,

A 27-year-old woman came to consultation for facial acne and hyperpigmented macules on the oral mucosa. Nearly 9 months before, she had been prescribed oxabolone cypionate for anxiety and depression, which had caused organic wasting and had led to a suicide attempt. Hyperpigmentation had appeared a few months after the onset of this therapy, while acne, which had preceded it, deteriorated. In addition, the patient complained of hyperpolymerorrhoea alternating with oligomenorrhea. There was no familial history of oral lentiginosis. She denied taking any other drug.

On examination, light brown macules were seen on the mucosa of her lips and cheeks. On the face there were comedones and papulo-pustules with some scars.

Laboratory tests showed a mild anaemia. There was no radiographic evidence of intestinal polyposis, and ultrasonography excluded any gross alteration of adrenal glands and ovaries.

A biopsy of a macule showed only an increased number of melanocytes in the basal layer of the epidermis.

The patient’s endocrine asset was studied for 6 months. Low cortisol levels with inversion of its circadian rhythm and occasional increases of the ACTH levels were observed. There was also an inversion of the LH/FSH ratio and low 17-β-estradiol levels. Progesterone, hydroxyprogesterone, both free and total testosterone, 6-4-androstenedione, dehydro-epiandrosterone and dehydro-epiandrosterone sulfate levels were all in the normal range. Daily sodium, potassium and 17-ketosteroid urinary excretions were also normal. A dynamic ACTH stimulation test excluded a primary adrenal insufficiency and any adrenal enzymatic deficiency as well.

Both pigmentation and endocrine irregularities slowly faded after the discontinuation of the drug.

Oxabolone cypionate (4,17-β-dihydroxysteradiol-4-en-3-one17-(β-cyclopentylpropionate, Steranabol Depot, Farmitalia) is an anabolic steroid, characterized by a delayed activity which allows it to be given every 8-10 days. It is used in protein and bone wasting and, though forbidden, in athletic training.

It is likely that oxabolone treatment deranged the endocrine asset of our patient and worsened the acne. Unexpected, however, was her oral pigmentation. Perusal of literature reveals that a few drugs may cause hyperpigmentation of mucosa. They include adynamelic and busulfan, ACTH, antimalarial agents, heavy metals and inorganic arsenic. Androgens have been reported to cause hypermelanosis (1) and oral lesions (methyltestosterone, testolactone (2) and oxymesterone (3). Though it has been in the market for about 30 years, oxabolone has never been reported to do so.

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