Tubular atrophy and interstitial fibrosis may occur in systemic sclerosis, but tend to depend on the severity of sclerosis-associated vascular changes. Although we cannot entirely rule out that an increase in interstitial connective tissue in the scleroderma patients could be disease-related rather than treatment-related, this does not appear to be the case for the psoriasis patients. Kidney biopsies in uncomplicated psoriasis have been found normal (7).

The present preliminary study gives no information concerning the clinical relevance of the minor changes we have found hitherto, and does not exclude the use of cyclosporin A in severe psoriasis or severe systemic sclerosis when necessary. But we feel it important that long-term renal toxicity should also be taken into consideration in so-called low-dose cyclosporin therapy of these diseases.

REFERENCES


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Oral Hairy Leukoplakia

Sir,

Reggiani & Pauluzzi reported a case of oral hairy leukoplakia in a liver transplant patient (1). Although hairy leukoplakia was first described exclusively in patients infected with the human immunodeficiency virus (HIV), the virus was never found in the lesions, but the absence of Langerhans’ cells indicates a dysfunction of the immune system (2).

On the other hand, Epstein-Barr virus (EBV) is a regular finding and hairy leukoplakia is considered today to be an opportunistic infection of the tongue by EBV (2). Since EBV can be found in oropharyngeal excretions in immunosuppressed as well as in healthy people (3) and EBV receptors are present in the parakeratinized oral mucosa (4), it is not surprising that several cases of hairy leukoplakia in immunosuppressed patients without evidence for HIV infection have been reported recently (Table 1).

(5–9). However, EBV-DNA has never been detected in hairy leukoplakia-like lesions in individuals without immunosuppression (10). Therefore, in individuals lacking evidence of HIV infection, hairy leukoplakia-like lesions should be confirmed by detection of EBV-DNA.

REFERENCES

4. Corso B, Eversole LR, Hutt-Fletcher L. Hairy leu-
Table I. Oral hairy leukoplakia-like lesions in HIV-negative patients

| Author          | Immunosuppression       | Histology EBV-DNA
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Birek (8)</td>
<td>Bone marrow transplantation</td>
<td>+</td>
</tr>
<tr>
<td>Epstein (9)</td>
<td>Bone marrow transplantation</td>
<td>+ nd</td>
</tr>
<tr>
<td>Greenspan (6)</td>
<td>Renal transplantation</td>
<td>+</td>
</tr>
<tr>
<td>Itin (5)</td>
<td>Renal transplantation</td>
<td>+</td>
</tr>
<tr>
<td>Reggiani (1)</td>
<td>Liver transplantation nd</td>
<td>nd</td>
</tr>
<tr>
<td>Syrjänen (7)</td>
<td>Chemotherapy (leukemia)</td>
<td>+</td>
</tr>
</tbody>
</table>

*EBV-DNA detected by in situ hybridization, nd: not done.


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Neuron-specific Enolase-immunoreactive Fibres in Uremic Patients

Sir,

We have read with interest the recent study by M. Stähle-Bäckdahl (1), in particular the immunohistochemical findings in patients with uremic pruritus who were undergoing maintenance haemodialysis. The author found a striking difference in the histopathographical distribution of neuron-specific enolase (NSE)-immunoreactive skin nerve terminals when comparing haemodialysed patients and control volunteers. Specifically, NSE-positive fibres were observed to enter and sprout throughout the epidermis in all patients, whereas they could be detected only in the stratum basale of the healthy controls. Such findings would suggest an anatomical explanation for uremic pruritus, although NSE intra-epidermal immunoreactivity was found, irrespective of itching (2, 3).

We would like to report results on NSE skin immunoreactivity in 24 patients and 10 control subjects, which are at variance with these observations. We could observe a pattern of intra-epidermal ‘sprouting’ of NSE-positive varicose nerve endings, as described by M. Stähle-Bäckdahl and co-workers, in only 3 patients. In a few of the remaining patients, isolated epidermal fine positive terminals were occasionally detected. No difference in the distribution of dermal NSE immunoreactivity between uremic patients and controls was seen. However, we did find a certain reduction in the total number and intensity of NSE-stained fibres in the uraemic group, compared with the control group. Interestingly, in agreement with previous reports (4), we could observe sporadic NSE-immunoreactive free nerve endings also in the epidermis of control samples collected from various body areas (Fig. 1). Furthermore, intra-epidermal free nerve endings have been observed by other authors, not only in lesional skin (5, 6) but also in normal specimens (7).

In conclusion, these data would suggest that it is

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