

- pilomatrix carcinoma: report and review of literature. *J Am Acad Dermatol* 1990; 23: 985–988.
4. Niedermeyer HP, Peris K, Hofer H. Pilomatrix carcinoma with multiple visceral metastases. Report of case. *Cancer* 1996; 77: 1311–1314.
  5. Inglefield CJ, Muir IF, Gray ES. Aggressive pilomatricoma in childhood. *Ann Plast Surg* 1994; 33: 656–658.

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Arun Joshi<sup>1</sup>, Shatrughan P. Sah<sup>2</sup>, Chandra Shekhar Agrawal<sup>3</sup>, Mary Jacob<sup>1</sup> and Arun Agarwalla<sup>1</sup>  
 Departments of <sup>1</sup>Dermatology and Venereology, <sup>2</sup>Pathology and <sup>3</sup>Surgery, BP Koirala Institute of Health Sciences, Dharan, Nepal.

## Topical Calcipotriol in Childhood Psoriasis

Sir,

Between January 1994 and March 1997, 20 children (13 males and 7 females) ranging in age from 2 to 13 years affected by mild, stable psoriasis were treated with calcipotriol ointment 50 µg/g (Psorcutan pomata, Schering).

Exclusion criteria included children with acute guttate psoriasis and with, or with past history of erythrodermic or pustular psoriasis. None of the children had any systemic treatment in the 2-week period before or during the trial and none of them had applied or were applying topical steroids in these two periods. In all patients, the area of skin treated did not exceed 10% of the total body surface area. We did not use calcipotriol ointment on the face, scalp, genitalia, nails or hands and feet, even though in six patients one or two of these areas was also affected.

The treated lesions were one or more erythematous-squamous nummular patches, 20–50 mm in diameter, in 15 patients, round guttate patches, less than 10 mm in diameter, in 4 patients and inversus psoriasis with a single patch on the right axillary fold in 1 patient. The lesions were located on the limbs (12 cases), the trunk (8 cases) or both (3 cases).

After receiving informed consent from the children's parents we proposed medication with calcipotriol ointment once a day (at night) without occlusion for the first week of treatment. In the morning a urea-based cream or a simple emollient was applied on the basis of scaliness value. If no irritant cutaneous reactions, such as redness or burning, were observed at the end of the first week we suggested twice daily applications of calcipotriol ointment for 8 weeks or until complete remission. Patients were examined every 2 weeks during the trial period.

Clinical assessment used a score system that considered the morphology and number of the lesions: in every patient we chose the most typical or the only patch of psoriasis and from this we measured the intensity of erythema, thickness and scaliness. Moreover, at the start and at every 2-weekly consultation we counted the exact number of patches. We considered results as: no change (25% improvement in number and morphology of lesions); slight improvement (25–50%); marked improvement (50–70%); or clearance (over 75%). In this manner, the value of severity at baseline was arbitrarily considered to be 100% in every patient and at each consultation any improvement was evaluated relatively for each case. No other available score was found because the

PASI score at baseline was already too low to show any improvement at subsequent consultations.

### RESULTS

After 8 weeks we observed a marked improvement in nine cases. Clearance was noted in six patients after 3–5 weeks of the therapy. No change was seen in two, and three withdrew because of local irritation. The maximum amount of ointment used during the 8-week trial never exceeded a single tube (30 g).

### CONCLUSION

Our trial was limited to minimal childhood psoriasis, which shows remissions and relapses characterized by only one or few patches confined to a single site of the body and involving less than 10% of the cutaneous surface (1). In our opinion calcipotriol ointment is effective and safe in the treatment of such patients and it is a good alternative to the use of topical steroids. Similar results have been reported in the literature in other studies on children (2–4).

### REFERENCES

1. Bianco P, Iurassich S, Costanzo R, Rossi A. Psoriasi infantile studio clinico-epidemiologico sui casi osservati negli ultimi 5 anni. *Chron Derm* 1997; VII: 35–44.
2. Oranje AP, Marcoux D, Svensson A, Prendville J, Krafchik B, Toole J, et al. Topical calcipotriol in childhood psoriasis. *J Am Acad Dermatol* 1997; 36: 203–220.
3. Fabrizi G, Vultaggio P. Calcipotriol and childhood psoriasis. *J Dermatol Treat* 1997; 8: 221–223.
4. Darley CR, Cunliffe WJ, Green CM, Hutchinson PE, Klaber MR, Downes N. Safety and efficacy of calcipotriol ointment (Dovonex<sup>®</sup>) in treating children with psoriasis. *Br J Dermatol* 1996; 135: 390–393.

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Annalisa Patrizi, Iria Neri, Laura Rizzoli and Claudio Varotti  
 Department of Clinical and Experimental Medicine, Division of Dermatology, University of Bologna, Via Massarenti 1, IT-40138 Bologna, Italy.