in O/W cream without occlusion gave very satisfactory initial results (4 months). After 3 years on a dosage ranging from 0.1 to 0.3 mg/kg etretinate, combined with topically applied steroids of the two most potent classes at, on average, 20 g a week, 41% of those who did well after the initial treatment were still in a good condition.

The question remains as to whether the absence of relapses in a proportion of our patients was due to the maintenance treatment or to spontaneous remissions. Data on untreated psoriasis patients followed up for 3 years are lacking, for obvious reasons. Vella Briffa et al. (5) reported that the proportion of patients who can be expected to be in a good condition 16 months after clearing by dithranol treatment without further therapy is about 20%.

We found (Table I) after 2 years that at least 20 (51%) of the 39 patients whose condition was evaluated as 'very good' after the initial treatment were just as well 2 years later. Although it is not possible to compare these two sets of data by statistical methods, they point to a favourable effect of the maintenance treatment. A similar indication is given by the finding that incipient relapses reacted favourably to an increase in both the oral dosage and the topical theraphy.

The proposed treatment offers a valuable addition ot the available treatment modalities for psoriasis, affords results comparing favourably with dose obtained with PUVA, UVB, Dithranol, or other combinations with etretinate (Re-PUVA, Re-UVB, and Re-anthralin), is also more convenient for the patient and is safer, provided that women of child-bearing age use a safe form of contraception.

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More comprehensive bibliography in refs. 1, 3 and 4.

Onychotillomania Treated with Pimozide (Orap®)

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Abstract. A case of onychotillomania in a 70-year-old woman is presented. The disease had persisted for 5½ years. All her fingernails were plucked away. The patient had a fixed hypochondrial delusion of nail disease. After treatment with pimozide (Orap®) for 7 months the nails were normal.

Key words: Onychotillomania; Paranoia hypochondriaca; Pimozide (Orap®)

Very few cases of onychotillomania have been published (1, 2). The condition is usually regarded as a manifestation of a compulsive neurosis (1, 2) though Combes & Scott (1951) presented a case of delusions of infestation where the symptoms were focused on the nails.

CASE REPORT

A 70-year-old woman with no previous psychiatric disease was referred because of a nail disease of 5½ years' dura-

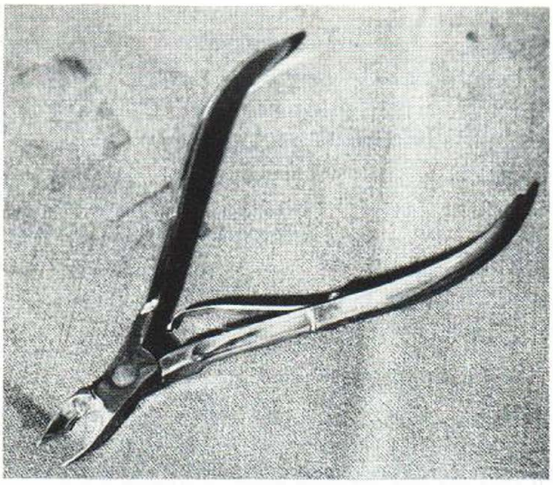

Fig. 1. Nail scissors used. Note the acute distal angles.

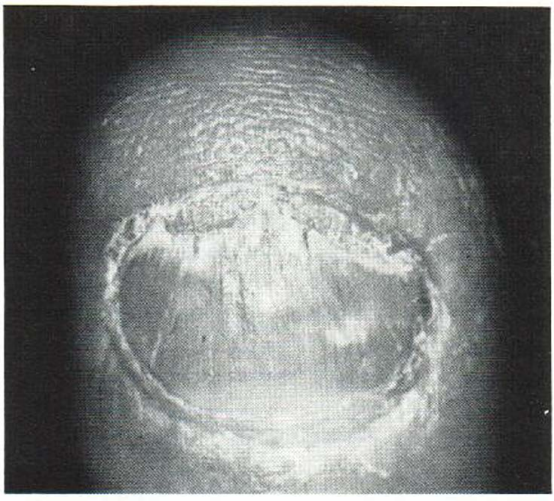

Fig. 3. Fourth right finger after 3 months of treatment.

tion. The affection had worsened during the last 2 years. The patient reported that the nails broke and hurted. She had to clean her nails with soap chlorine and rough sponges. She used special nail scissors (Fig. 1) to remove the disease which presented as "hardness" at the nailplate and around the nail. The design of the nail scissors made it easier to pick out the "hardness" from under the cuticula.

The patient was convinced that she had a disease in the nails and the surroundings which presented as described. A sister of hers had had almost the same symptoms for about 3 years. They regularly discussed their disease over the telephone and helped each other to find new ways to get rid of the disease. (The sister used a hobby knife and had skin artefacts too—a *folie à deux* situation.)

Clinically all the nails of the hands had been plucked away (Fig. 2). Only the big toe nails were partly affected on the feet.

The patient was treated with pimozide (Orap®) 2 mg daily increasing every 2 weeks (1 mg) to 4 mg daily. After 2 months the dose was reduced to 3 mg daily. The patient was checked every second to fourth week. After 3 months the nails had improved (Fig. 3) and after 7 months (Fig. 4) all were perfect. Because of a tendency to manipulate still, the treatment was continued at 2 mg pimozide (Orap®) daily.

(The sister was treated with Orap® too. Her skin artefacts stopped and at the latest check-up she only complained of brittle nails.)

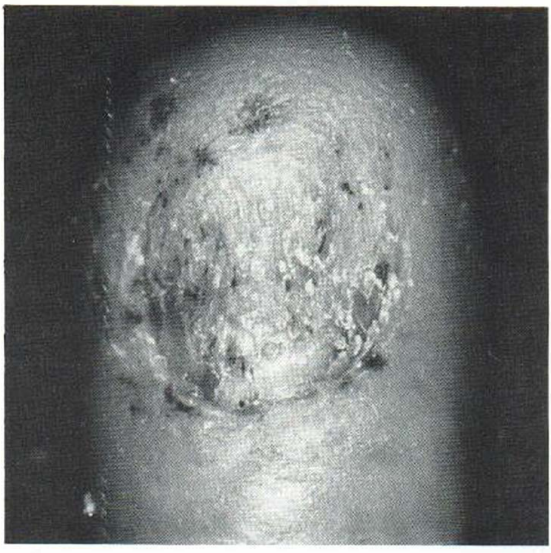

Fig. 2. Onychotillomania. Fourth right finger at the first consultation.

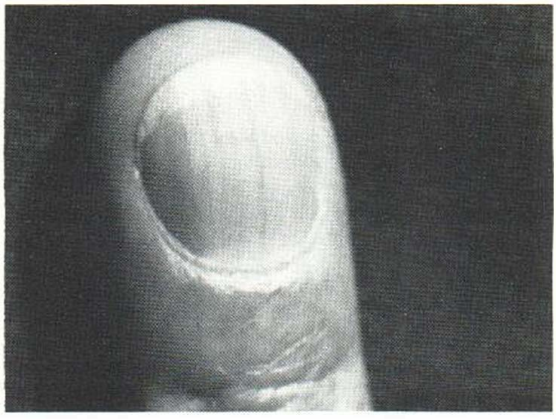

Fig. 4. Fourth right finger after 7 months of treatment with pimozide.

DISCUSSION

The patient described the method by which the nails were destroyed. She was convinced that she was diseased, and did not realise that she produced the changes herself. Thus she had a fixed hypochondrial delusion of nail disease and in addition a *folie à deux* situation with her sister. It was impossible to convince her that the 'hardness' which she demonstrated was normal nail material and normal skin—she was clearly deluded.

Delusions of infestations can be treated by pimozide (3). Because of the monosymptomatic hypchondrial nail paranoia—which can be included in the same psychotic group of paranoia hypochondriaca as delusions of infestations (4)—the patient was treated with pimozide (Orap®), with excellent results.

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Co-existence of Venereal Infection and Pediculosis pubis

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Abstract. Over a 5-year period we found an incidence of 15.3% of gonorrhea in women and 7.2% in men attending the dermatology department with Pediculosis pubis. Moreover there was a 1.5% incidence of syphilis in men. These results clearly indicate that this group of patients is a reservoir of venereal infection. Consequently it must be strongly advised to carry out a complete venereological examination in every adult with Pediculosis pubis.

Key words: Pediculosis pubis; Venereal disease

In recent years several attempts have been made to identify the reservoirs and risk groups for sexually transmitted disease (5). Scandinavian studies have shown significant rates of asymptomatic gonorrhea in gynecological departments, family planning clinics and in patients with scabies (1, 2, 3, 4, 6).

Pediculosis pubis in adults, when found in the anogenital region, is considered to be sexually transmitted. To test the general statement of co-existence of venereal infestations and infections it was decided to carry out a 5-year survey in patients with Pediculosis pubis.

MATERIAL AND METHODS

Since 1964 all women, and from 1974 all men, who were admitted to the Department of Dermatology, Municipal Hospital, Copenhagen and had a pubic crap louse or eggs thereof were offered a complete venereological examination, including anogenital inspection, cultures taken from the tonsils, urethra, rectum and in women from the cervix to be tested for gonorrhea, together with blood samples for syphilis serology, by Statens Seruminstitut, Copenhagen.

From 1.9.74 to 1.9.79 crap louse was found in 69 women and 167 men, the majority belonging to the age group between 14 and 35 years.

RESULTS

Gonorrhea

59 women and 139 men accepted examination, 9 women, or 15.3% (confidence limit 95%: 7.2–27.0%) and 10 men, or 7.2% (confidence limit 95%: 3.5–12.8%), altogether 9.6% (confidence limit 95%: 5.8–14.5%) had gonorrhea.

One patient was referred to the gynecological department with a spread of the infection to internal organs. Another woman had a positive culture only from the tonsils and, together with the remaining 7 patients, was asymptomatic.

One of the men had a positive culture from the rectum only; 5 had a history of mild urethral discharge and the rest were asymptomatic.

Syphilis

60 women and 133 men were tested with syphilis serology. None of the women were positive.

5 men, or 3.8%, had a positive test; 3 of these were known and controlled infections. The remaining 2 men, or 1.5% (confidence limit 0.1–3.6%) were found to have early syphilis without observed chancre.

No cases of chancroid or lymphogranuloma venereum were found.