

perivascular lymphohistiocytic infiltrate with scattered atypical lymphoid cells, interstitial eosinophils, and mast cells, which was consistent with a drug reaction. The abdominal ultrasound result revealed steatosis hepatis without other pathologic findings. With systemic and topical corticosteroids, the rash rapidly subsided so that the dose of methylprednisolone was tapered to 8 mg. However, liver enzymes were still increasing up to 20-fold (aspartate aminotransferase, 22.84 mmol/L; alanine aminotransferase, 11.89 mmol/L) at day 7 after admission. Therefore, prednisolone was introduced at 100 mg/d and continued for another 4 weeks under gradual dose reduction. Liver enzymes finally returned to normal 10 weeks after the onset of exanthema. Two months later, a patch test was performed with Potaba-Glenwood® 500 mg Capsules ground in a mortar 1:1 in Vaseline and applied on the back of the patient in a Finn Chamber. Testing and scoring procedure were performed according to the guidelines of the German Contact Dermatitis Research Group and revealed a strongly positive reaction at 48 hours (++) and 72 hours (+++) with multiple papulovesicles.

The photosensitizing potential of PABA as a chemical sunscreen filter causing photoallergic contact dermatitis has been frequently reported. However, little is known on possible allergic reactions after ingestion of the potassium salt of PABA used for treatment of fibrotic skin diseases such as Peyronie's disease. Recently, this substance was recognized as a systemic photosensitizer causing systemic photoallergic contact dermatitis in a construction worker during therapy with Potaba.¹ The observation of liver toxicity after intake of potassium-PABA had raised the question of its impact on liver function tests, which, however, did not seem to be significantly influenced in a retrospective study on 390 patients with scleroderma.² So far, 6 cases of liver injury associated with Potaba were described, mostly referred to as hepatotoxic.^{3–5} In few patients, also an immuno-allergic mechanism was suspected.⁴ In our case, we could demonstrate that rash and liver involvement were due to a DRESS syndrome, showing typical clinical, histologic, and laboratory findings. The positive patch test with a crescendo reaction to this substance points to a specific T-cell-mediated allergic reaction. In case of exanthema after introduction of therapy with potassium-PABA, the patient should be monitored for DRESS syndrome, and the medication should be discontinued immediately.

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Patch Testing in Young Children Should Not Be Overlooked

To the Editor:

We are writing in response to a statement made by Mussani et al, indicating that “there is no proven efficacy” in patch testing younger patients. This has not been our experience. A study performed by the University of Miami and University of Pennsylvania showed an 83% prevalence rate of positive patch-test reactions and 77% clinical relevance in patients aged 1 to 18 years.¹ Furthermore, the North American Contact Dermatitis Group found no significant difference in the frequency of at least 1 relevant positive patch-test reaction when comparing children (age range, 0–18 years) and adults, 51.2% compared with 54.1%, respectively.² Therefore, not only has pediatric patch testing been shown to be clinically efficacious but relevant as well.

The European literature also speaks to the importance of patch testing in pediatric populations, with Roul et al³ reporting a positive patch-test rate of 66% in children aged 1 to 15 years, with the highest incidence among children younger than 3 years. Moreover, another study looking at 670 patients aged 6 months to 12 years revealed a 42% positive patch-test prevalence rate, with the peak sensitization found in children 0 to 3 years.⁴ In addition, a large study of 997 pediatric patients in Italy showed a 52.1% allergic prevalence rate, with the highest sensitization rate again being in the 3 years and younger age group.⁵ In fact, 1 study specifically showed that 200 children aged 3 to 36 months developed at least 1 positive patch-test reaction.⁶

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With allergic contact dermatitis in children being an increasingly recognized problem, the benefits of pediatric patch testing must not be overlooked. Although the procedure itself and logistics of the testing may prove challenging in very young populations, the end results are often worthwhile, especially in those patients with chronic recalcitrant dermatitis.

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