



Fig 1. Erythrodermic psoriasis after discontinuation of efalizumab treatment despite a combination therapy of methotrexate and infliximab.

their disease. A rebound phenomenon is defined as a recurrence of the disease with a PASI score greater than 125% of the baseline score or the development of new widespread pustular, erythrodermic or more inflammatory psoriasis lesions occurring within 8 weeks from discontinuation of treatment in responding patients.¹

Considering this definition, approximately 13.8% of treated patients develop a rebound phenomenon after discontinuation of treatment,² and this entity is more frequently observed in nonresponsive patients. International guidelines recommend the introduction of a systemic and fast-acting therapy such as ciclosporin or high-potency steroids. Psoralen plus ultraviolet A therapy, systemic retinoids and slower-acting therapies seem to be less effective in this context.² In our patient methotrexate and, most importantly, infliximab, were not effective, the latter being associated with a severe worsening.

A flare of atopic dermatitis due to infliximab, as described with tumour necrosis factor- α antagonists,^{3,4} could be excluded for our patient because there was no personal or family history of atopy and biological findings were unremarkable. The resistance to a potent combination therapy contrasts with the extremely rapid improvement after initiation of an intensive topical treatment, effectiveness that has already been described in the past.² Therefore severe forms of rebound phenomenon occurring after withdrawal of biologic

agents may not always require first-line treatment with rapid-acting systemic therapy.

Department of Dermatology,
University Hospital of Geneva,
24 rue Micheli du Crest, CH-1211 Geneva,
Switzerland

E-mail: anne-marie@thielen.net

A.M. THIELEN
C. BARDE
J.H. SAURAT

References

- 1 Thielen AM, Kuenzli S, Saurat JH. Cutaneous adverse events of biological therapy for psoriasis: review of the literature. *Dermatology* 2005; **211**:207–15.
- 2 Leonardi CL. Efalizumab in the treatment of psoriasis. *Dermatol Ther* 2004; **17**:393–400.
- 3 Dumont-Berset M, Laffitte E, Gerber C et al. Eczematous drug eruption after infliximab. *Br J Dermatol* 2004; **151**:1272–3.
- 4 Wright RC. Atopic dermatitis-like eruption precipitated by infliximab. *J Am Acad Dermatol* 2003; **49**:160–1.

Conflicts of interest: none declared.

Parthenium contact sensitivity travels to the U.K.

DOI: 10.1111/j.1365-2133.2006.07444.x

SIR, Contact sensitivity from the weed parthenium is well recognized. It does not grow in the U.K., but is a particular problem in India where parthenium dermatitis is the most common type of airborne contact dermatitis.¹ Patients often require prolonged courses of systemic corticosteroids to achieve control of their symptoms. There are no reports in the European literature of this condition occurring in Pakistan.

A 67-year-old Pakistani man presented with a 10-year history of eczema on the face, neck, hands and, at times, trunk and limbs. He was retired and enjoyed gardening. He lived in Islamabad but frequently visited his daughter in the U.K. When in this country his condition spontaneously improved. Previous treatments in Pakistan included both topical and systemic corticosteroids.

Skin biopsy from the forehead demonstrated a spongiotic dermatitis in keeping with lichen simplex chronicus changes.

In view of the airborne pattern of his rash he was patch tested to the standard series, Compositae mix, his own medicaments and a series of plant allergens held in our clinic. At both 48 and 96 h he reacted strongly positive to sesquiterpene lactone mix and Compositae mix. He also reacted strongly to tansy and feverfew in our plant series.

The severity of this man's dermatitis, its distribution and clear improvement whenever he was away from Pakistan, asso-



Fig 1. *Parthenium hysterophorus*. Photograph with permission of Charles T. Bryson, U.S.D.A. Agricultural Research Service (<http://www.invasive.org>).

ciated with a Compositae allergy, was felt to be similar to cases reported from India due to allergy to *Parthenium hysterophorus*. We asked that further enquiries be made regarding the local flora as we were unaware whether *P. hysterophorus* was also found in Pakistan. The patient's nephew confirmed that this weed flourishes in and around Islamabad. Of particular relevance was the subsequent discovery of an article by Nadeem et al.² that confirmed that *P. hysterophorus* is found growing in many parts of Pakistan including Lahore, Johar town and the Changa Manga forest. In some places it has replaced the native flora and has contaminated nearby grain-producing areas. They studied a total of 511 patients with contact dermatitis and 100 patients with other dermatological diseases (not eczema). On patch testing 391 patients demonstrated positive reactions to either the leaf or flower or to 1% parthenin in petrolatum base, as compared with five individuals in the control group. All the subjects were field workers and the reactions were therefore felt to be highly relevant.

Parthenium hysterophorus is a wasteland weed which is hazardous to plants and humans (Fig. 1). Its common local names include congress weed, carrot weed, star weed, feverfew, white top, chatak chandani, bitter weed, ramphool and garghas.² The plant is capable of growing in all types of soil and throughout the year due to low water requirements.³ As a consequence it can spread rapidly once established. This weed originates from countries bordering the Gulf of Mexico, but has been growing for centuries in many parts of the world including South Asia, the Americas, Australia and the West Indies.⁴ *Parthenium* is well recognized as a cause of airborne contact dermatitis in Northern India where it was introduced accidentally in the mid 1950s along with wheat grains from the U.S.A. Apart from an airborne distribution, contact sensitivity to parthenium can present as erythroderma and also as a more generalized chronic eczema.¹

We highlight this case as there are no reports in the European literature of airborne contact dermatitis from

P. hysterophorus occurring in Pakistan. However, it seems to be a growing problem in this country where in certain cities such as Islamabad and Lahore it has replaced the native flora.² In view of the considerable amount of travel taken these days, patients travelling to or from this part of the world may present to our dermatological services. Awareness of the spread of this common plant allergen needs to be borne in mind when seeing patients from this part of the world.

Contact Dermatitis Investigation Unit,
The Dermatology Centre, Hope Hospital,
Salford M6 8HD, U.K.
E-mail: minalnshah@hotmail.com

M.N. SINGH
M.H. BECK

References

- 1 Pasricha JS. *Contact Dermatitis in India*. New Delhi: All India Institute of Medical Sciences, 1998.
- 2 Nadeem M, Rani Z, Shahbaz A et al. *Parthenium* weed: a growing concern in Pakistan. *J Pak Assoc Dermatol* 2005; **15**:4–8.
- 3 Towers GHN, Mitchell JC, Rodriguez E et al. Biology and chemistry of *Parthenium hysterophorus* L., a problem weed in India. *J Sci Ind Res* 1977; **36**:672–84.
- 4 International *Parthenium* Research News Group. Available at <http://www.iprng.org> (accessed 22 May 2006).

Conflicts of interest: none declared.

Development of oil cysts after subcutaneous injection of interferon- α and interleukin-2

DOI: 10.1111/j.1365-2133.2006.07445.x

SIR, Adjuvant immunotherapy of malignant melanoma often includes long-term subcutaneous treatment with interferon (IFN)- α and interleukin (IL)-2. These patients with stage III/IV melanoma are enrolled in frequent staging check-ups to enable early detection of metastasis. We here describe two patients who developed firm nodules on the lower abdomen misdiagnosed as subcutaneous metastasis of the primary melanoma.

Patient 1 was a 51-year-old male patient who was diagnosed with cutaneous metastases of malignant melanoma. The primary tumour was not found during intensive diagnostic measures. The metastases were excised and the patient received immunotherapy with IFN- α (3×9 million U week⁻¹) and IL-2 (2×6 million U week⁻¹). One year later, the patient developed firm nodules in the subcutis of the lower abdomen.

Patient 2 was a 75-year-old male patient with melanoma (nodular malignant melanoma on left shoulder at the age of