

Positive response to nickel and azathioprine treatment

Editor

Data and our understanding of azathioprine on patch test results remain largely unknown.

We report here a case of strong positive response to nickel in a patient who had been taking antimetabolite azathioprine for more than 2 years (at the daily dose of 100 mg/day).

A 38-year-old woman was presented to our hospital because of Behçet's syndrome.

She had oral aphthous ulcers and typically displayed a systemic dermatologic involvement of the syndrome. Since her Behçet diagnosis, her current medication had been azathioprine and aspirin. Moreover, the patient had endolymphatic hydrops (Meniere's disease).

Oral examination revealed several dental metal restorations in her teeth.

We suspected a potential association between allergy to metals, which were components of her intraoral metal alloys, and her chronic oral recurrent ulcers.¹⁻³

In particular, we envisioned the presence of trace amount of nickel in her alloy restorations.

To prove or to exclude this possibility, the patient was patch tested with both standard and dental series for screening for contact allergy to antigens, which were obtained from Chemotechnique, Malmö, Sweden.

However, the azathioprine treatment might have interfered with her immunological response to allergens during skin tests.

We decided to perform this challenge. Azathioprine was withheld 2 days before the beginning of patch testing. At day 4 (96 h), she showed a strong allergic reaction (++) to nickel sulphate 5% in petrolatum. Despite this consistent evidence, she declined to remove her intraoral metal alloys.

Uncertainty persists when we patch test individuals on immunomodulators.^{4,5} Few reports have assessed the interaction between immunosuppressors and patch testing.^{4,5}

However, this case illustrates that positive answer to nickel occurred in a patient even during azathioprine treatment.

The intensity of the positive response to nickel allergen seems to be unaltered by the long-term administration of the well-known immunosuppressor agent.

PD Pigatto,† A Cesarani,‡ S Barozzi,‡ G Guzzi*§
 †Institute of Dermatological Sciences, University of Milan,
 Maggiore Hospital, Mangiagalli and R. Elena Foundation,
 Milan, Italy, ‡Department of Otorhinolaryngology and
 Ophthalmology, University of Milan, Italy and §Italian
 Association for Metals and Biocompatibility Research –
 A.I.R.M.E.B., Milan, Italy, *Corresponding author, Italian

Association for Metals and Biocompatibility Research –
 A.I.R.M.E.B., Via F. Sforza, 15, 20122 Milan, Italy,
 tel. +39 02 782 561; fax +39 02 9197 585302;
 E-mail: gianpaolo_guzzi@fastwebnet.it

References

- 1 Pacor ML, Di Lorenzo G, Martinelli N *et al.* Results of double-blind placebo-controlled challenge with nickel salts in patients affected by recurrent aphthous stomatitis. *Int Arch Allergy Immunol* 2003; **131**: 296–300.
- 2 Tosti A, Piraccini BM, Peluso AM. Contact and irritant stomatitis. *Semin Cutan Med Surg* 1997; **16**: 314–319.
- 3 Axéll T. Hypersensitivity of the oral mucosa: clinics and pathology. *Acta Odontol Scand* 2001; **59**: 315–319.
- 4 Flori ML, Andreassi L. Patch tests after cyclosporin A treatment in hyper-reactive patients. *Contact Dermatitis* 1994; **31**: 32.
- 5 Vena GA, Foti C, Piazzola L, Angelini G. Can cyclosporin A help distinguish allergic from irritant patch test reactions? *Contact Dermatitis* 1994; **31**: 256–257.

DOI: 10.1111/j.1468-3083.2007.02493.x

Nail dystrophy in focal acral hyperkeratosis: a distinctive feature?

Editor

Focal acral hyperkeratosis (FAH) is often considered to be a variant of acrokeratoelastoidosis (AKE).^{1,2} Clinically, both disorders are believed to be transmitted in an autosomal-dominant fashion and manifest with identical features: discrete, small hyperkeratotic papules mainly located on the side and dorsal aspects of hands and feet. In contrast with FAH, AEK is characterized by prominent degenerative changes of elastic fibres (i.e. elastorrhexis). Recently, Van Steensel *et al.* reported a patient with AKE associated with pitted keratolysis and nail dystrophy. We wish to report a case of FAH accompanied by abnormal nail findings, suggesting that nail dystrophy may represent distinctive, but so far under-reported, features of AKE/FAH.

A 50-year-old woman of Arab Moslem extraction was referred to our outpatient clinic because of a 40-year history of a papular rash over her hands and feet associated with palmar erythema, hyperhidrosis and abnormal nail findings. Her deceased father and her daughter reportedly displayed similar clinical features. Her general health was good. On physical examination, multiple, translucent, skin-coloured papules of varying size were observed on the flexor aspects of her distal forearms, on the sides of her fingers and toes and on her hand dorsa (fig. 1). Her 10