

Patients and Methods

From 1994 to 1996, a total of 18 women with vulvodynia were consecutively referred to our patch test clinic. Clinical examination and vulval biopsies showed no signs of other skin or mucosal diseases. None of the women had local erythema, oedema or lichenification. Tenderness on pressure (cotton swab) was absent in all. Koilocytosis was described in 10 and minimal non-specific inflammation in 3. None were atopic and only 2 had known allergy to nickel. None had evidence of candidiasis, bacterial vaginosis, trichomonal infection, chlamydia or gonorrhoea. All were tested with the European standard series, a medicament series, topical corticosteroids and their own topical products.

Results

3 women had a + reaction to nickel at 2 and 3 days. All other patch tests were negative. Oral placebo-controlled provocation with nickel did not elicit a flare of symptoms in these 3 women.

Discussion

In this population of 18 women with vulvodynia, allergic or systemic contact reactions were of no, or minimal,

importance. 4 women with negative patch tests received prednisolone 30 mg daily for 1 week without effect, further excluding contact allergy as a significant factor. Previous studies have demonstrated contact allergy in women with chronic vulval dermatoses, such as lichen sclerosus, lichen planus and eczema (4, 5). However, women with vulvodynia seem to be at low risk of developing contact allergy, possibly because topical medications are ineffective, and may therefore be applied less, in this condition.

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Crescendo reactions to sodium lauryl sulfate and retinoic acid in irritant patch tests

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Between 2 (D2) and 3 day (D3) readings, allergic patch test reactions have been described as crescendo, and irritant patch test reactions as descrecendo (1, 2).

Patients and Methods

34 patients, without a history of atopy, were patch tested with 60 µl sodium lauryl sulfate 0.5% aq. and 60 µl retinoic acid 0.05% eth. in large Finn Chambers®. The

test substances were applied on the upper back. The patches were removed at D2; reactions were recorded according to ICDRG recommendations (3) at D2 and D3.

Results

When comparing the test reactions at D2 and D3, there were crescendo reactions (increased scores) to sodium lauryl sulfate in 17 patients (50%), no change in 16

Table 1. Patch test results with sodium lauryl sulfate (SLS) 0.5% aq. and retinoic acid (RA) 0.05% eth.

Test substance	D2	D3	Kinetic of test reactions	% (n)
SLS	0 (++++/++++)	0 (++++/++++)	unchanged	47% (16/34)
SLS	+ (++++/++++)	0 (++++)	descrecendo	3% (1/34)
SLS	0 (++++)	+ (++++/++++)	crescendo	50% (17/34)
RA	0 (++++/++++)	0 (++++/++++)	unchanged	65% (22/34)
RA	+ (++++/++++)	0 (++++)	descrecendo	35% (12/34)
RA	0 (++++)	+ (++++/++++)	crescendo	0% (0/34)

(47%), and decrescendo reactions (decreased scores) in 1 (3%). Retinoic acid patch tests resulted in crescendo reactions in 12 (35%) and unchanged scores in 22 (65%) (Table 1).

Discussion

These results differ from the widely accepted view that decrescendo reactions are typical of irritant patch-test reactions. One possible reason for this is that after patch removal, part of the test substance applied remains in the epidermis maintaining an irritant effect on the skin (4, 5). Alternatively, an irritant skin reaction, like any skin inflammation, requires a relatively prolonged time for its restoration. An irritant reaction would therefore not immediately terminate after removal of the irritant, but more likely take 1 to 2 days or longer before disappearing. However, both these explanations would also fit allergic patch test reactions. Hence, the kinetics of skin

reactions may not be a reliable guide to discriminating between irritant and allergic patch test reactions.

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Contact dermatitis in psoriasis due to propolis

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Key words: allergic contact dermatitis; psoriasis; cyclosporin; propolis; herbal remedies; medicaments. © Munksgaard, 1997.

Case Reports

Case no. 1

A 32-year-old man with psoriasis since the age of 22 years, was referred because of eczema on his arms. He had been treated with cyclosporin (CyA) (3 mg/kg/day) for 1 year and was applying calcipotriol and corticosteroids. He was patch tested with the GIRDCA standard series (Hermal-Trolab). After 2 and 3 days, there was a positive reaction to propolis 10% pet., as well as to colophony 20% pet. His history also revealed a previous episode of labial oedema after chewing propolis tablets.

Further enquiry revealed that he had occasionally applied his wife's hand cream on his arms, and that this cream contained propolis among its active ingredients.

Case no. 2

A 28-year-old man with widespread psoriasis since the age of 12 years, was referred because of erythematous vesicular lesions on his neck. He was patch tested with the GIRDCA standard series. After 2 and 3 days, there was a positive reaction to propolis 10% pet. The history revealed that he had been applying propolis cream for his psoriasis. He was also on current treatment with CyA.

Discussion

Allergic contact dermatitis has been described as quite a rare event in psoriatic patients (1–3). However, over the years, single cases of allergic contact dermatitis from many topical preparations have been reported, including coal tar, dithranol, calcipotriol, corticosteroids, etc. (4–7). Propolis is a resinous compound collected by bees from the buds of trees, and is widely used in many cosmetic and medicinal preparations because of its antiseptic and healing properties (8–9). In recent years, several cases of sensitization to propolis have been reported, though we have been able to find only 1 occurring in a psoriatic patient (9). Our cases confirm the finding that CyA treatment does not interfere with patch-test reactions (10%), while its therapeutic effect allows patch testing to be carried out in patients with previously too widespread psoriasis.

References

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