Discussion

OLP and OLE are mainly seen in dental clinics. Some studies have identified drugs as responsible (1): we were unable to do so. As in previous reports (2, 3), we found no clinical or histopathological differences between OLP and OLE. Many previous publications have associated OLE with allergy to mercury amalgam (4–7), in agreement with our findings. We consider that the term oral lichen planus should be reserved for the idiopathic condition, all in which a cause can be found being classified as oral lichenoid eruptions. In the presence of dental materials, patch testing should always be performed, since replacement can be curative.

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Allergic contact dermatitis from colophony and Compositae in a violinist

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A 47-year-old man had a 6-year history of persistent pompholyx hand dermatitis. This was controlled by regular potent topical corticosteroids and no aggravating factors were noted. There was no personal or family history of atopy. He was a violinist and had played daily for 30 years. He had managed a music and musical instrument shop for the last 2 years. Our patient was also an enthusiastic gardener, often working with bare hands, but had noted no exacerbate from this.

2 years prior to presentation, he had abruptly developed a severe vesicular eruption on the feet. This was attributed to contact allergy to footwear though no patch tests were performed. Subsequently, he avoided footwear containing PTBPF resin and had had no further foot problems.

Patch testing to the European standard, corticosteroids, medicaments, and plant series were performed, with Finn Chambers on Scanpor removed at D2. D4 readings showed positive reactions to colophony (+++), fragrance mix (+++), PTBPF resin (++), lanolin (++), paraben mix (++), Compositae mix (+++), dandelion (++) and daisy (++).

An informal telephone survey of prominent UK violin retailers suggests that colophony dermatitis (1, 2) is rarely encountered. A much more common problem for violinists is allergic contact dermatitis from nickel.This is conspicuous, as it primarily affects the index finger, due to contact with the ferrule and throat of the bow that are made of metal. Rosin (colophony) applied to the bow contributes importantly to the sound produced. No suitable alternative is available. Low-dust variety and liquid varieties are marketed, but these are only beneficial in colophony-induced asthma or eye irritation. Cotton gloves are impractical because of the dexterity required. Rosins used in the UK are of unmodified type. Modification of rosins may reduce their capacity for sensitization. However, this alters their consistency and thus the quality of sound produced.

It is no surprise that the patient was positive to fragrance mix, as this is the case in 60% of colophony-allergic patients. Patients with multiple allergies are more easily sensitized (3). It may be that allergy to Compositae developed later, as Compositae allergy can be facilitated by pre-existing allergic contact dermatitis. Patients with Compositae allergy commonly have a propholyx-type hand dermatitis, as in our patient (4).

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