

Psoriasis of the hands köbnerizing in contact dermatitis

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Key words: allergic contact dermatitis; thiuram mix; rubber chemical; rubber gloves; psoriasis; Köbner effect; occupational; dental staff. © Munksgaard, 1998.

Case Report

A 35-year-old woman with long-standing psoriasis resumed work as a dental nurse, where she wore latex rubber gloves for much of the time. Her hands had been free from psoriasis, but some months later, she developed a severe eruption on the dorsa of both hands. On examination, there was confluent erythema and scaling of the dorsa of the hands, with a sharp cut-off at the wrists (Fig. 1). Patch testing to an extended European standard series showed a positive reaction to thiuram mix, confirming rubber glove allergy. Her psoriasis improved with topical mometasone furoate cream and the use of plastic instead of rubber gloves.



Fig. 1. Psoriasis on the dorsa of hands; sharp cut-off at wrists.

Although there may be a lower risk of sensitization in psoriasis overall (1, 2) it is suggested that the incidence is increased in palmoplantar psoriasis (3). A recent study of contact allergy in 75 patients with psoriasis (4), however, found a 25% incidence of positive patch tests, irrespective of morphology. Köbnerization has been reported in 38 to 76% of patients with psoriasis (5). Allergic contact dermatitis causing köbnerization of psoriasis should be considered in deterioration of psoriasis or resistance to treatment. Irritant contact dermatitis may also exacerbate psoriasis (6, 7), particularly of the hands.

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Photoallergic contact dermatitis from fepradinol

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Key words: fepradinol; photoallergy; adverse drug reactions. © Munksgaard, 1998.

Case Report

A 71-year-old woman, with Fitzpatrick skin type II, had has an itchy rash suggestive of contact photodermatitis for 3 days. She had had psoriasis for 14 years, and a

history of hypertension, but did not take any systemic therapy. Her eruption had begun 1 week after using Uticox[®] (meloxicam) and Dalgen[®] spray (fepradinol) to relieve pain in the right knee. She said that she had used fepradinol 2 months before without any problem. Ex-

amination revealed, on sun-exposed areas of the left cheek, neck and nape, erythematous edematous itchy plaques that subsided with corticosteroid therapy.

Once cleared, a photopatch test was done using the GEF (Photodermatology Spanish Group) standard series of allergens, plus meloxicam 1% pet. and fepradinol 1% pet. After 2 days, 1 set of the duplicated patch tests, which were all negative, was irradiated with 10 J/cm² UVA. The unirradiated patch test with fepradinol remained negative at D4, while the irradiated patch test with fepradinol had become positive (+ +).

Discussion

Izu et al. (1) reported the 1st case of contact allergy to fepradinol. Since then, new cases have been described (2–5), without finding cross-reaction with other NSAIDs (1), although Gonzalo & Revenga (6) described multiple sensitization to non-steroidal anti-inflammatory drugs, among them fepradinol. Fepradinol is considered an adrenergic compound (7), due to its structural similarity with other α -adrenergic drugs, but Goday et al. (8) did not find cross-reaction with other phenylethanolamines.

Our patient shows photocontact allergic dermatitis from fepradinol, confirmed by photopatch test. The absence of reaction in the application areas and development of dermatitis on sun-exposed areas suggests transport of the allergen by contaminated hands. To the best

of our knowledge, this is the 1st reported case of photoallergic contact dermatitis from fepradinol.

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The nickel released from jewelry in Israel and its clinical relevance

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The main aim of this study was to measure the amount of nickel released from jewelry available in Israel. We also evaluated the relevance of the results and the relationship between nickel sensitivity, atopy and hand eczema.

Materials and Methods

500 female patients who had been referred to dermatology outpatients, Rabin Medical Center, for any reason, were selected at random and requested to submit all their jewelry for a dimethylglyoxime test (DMT) on site. The reagents used were fresh 1% dimethylglyoxime solution in alcohol and 10% ammonium hydroxide solution in water. Each item was cleaned with 70% alcohol to remove perspiration and dirt. After drying, the DMT was performed as described in the literature (1), a reaction being considered positive with a red or pink color on the swab. All doubtful reactions were excluded from

analysis. All tests were performed by the same investigator (SK). All patients who participated completed a questionnaire on basic information, dermatological disease and atopy. In addition, we evaluated another 32 female patients with known nickel-positive reactions. They were requested to participate in a study unaware of its nature. After medical examination, their jewelry was tested by the same method and they completed the questionnaire. As a control group, the jewelry of an additional 250 female contact dermatitis patients were tested with DM. These patients had positive patch tests to at least 1 allergen, but none had nickel dermatitis or positive nickel reaction on patch testing. Statistical evaluation was made by computerized SAS analysis.

Results

Table 1 summarizes the results for 1037 jewelry items collected from the 500 random patients. In Table 2, the