

fection.³ This, together with its use in verruca vulgaris, plantar and genital warts, and tinea, has given me considerable experience that suggests that glutaraldehyde as reported by DesGroseilliers and Brisson may be useful in epidermolysis bullosa with the following technique.

The starting strength of buffered glutaraldehyde should be 2% for nightly use. Within one week, there should be adequate control, when it may be used every other night. If glutaraldehyde is still effective at this schedule, the remaining glutaraldehyde that the patient has may be diluted with an equal amount of water to provide a 1% solution. If refrigerated, the antimicrobial effect on secondary invaders may be maintained up to six weeks. Thereafter, it is likely that unbuffered glutaraldehyde may control epidermolysis bullosa by its tanning and hardening action.

I have seen one bona fide case of sensitivity from glutaraldehyde in an inhalation aide who had suffered intense exposure. Since there is no specific treatment for RBEHF, glutaraldehyde therapy can be useful.

The brown discoloration can be minimized by using the 2% strength. Patients have advised me that three baths will remove the stain. When treatment is limited, the buffering of glutaraldehyde enhances its broad antibacterial spectrum. Once the vesiculation is controlled, buffering is probably necessary only where there is secondary infection. In India, pitted keratolysis is prevented in bare-footed natives by painting the soles with formaldehyde, an analogue of glutaraldehyde, which is much more sensitizing. Any drug can sensitize or irritate. The physician's awareness of this fact, when confronted by a patient with an untreatable disease, and informing the patient and parent of the risks of treatment will allow glutaraldehyde to be successfully used. Contact dermatitis is easily treatable when the case is known.

I have had many requests for information on where to get glutaraldehyde. Any large hospital with an inhalation therapy department may be using buffered glutaraldehyde as a sterilant. Union Carbide, Ethicon, and the Arbrook companies provide it. It is supplied as a 25% solution, by Matheson, Coleman and Bell, in 1-kg

volume bottles, to which sodium bicarbonate is added to a pH of 7.5.⁴

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References

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2. Gordon HH: Herpes zoster and simplex: Local therapy with glutaraldehyde. *Cutis* 12:918, 1973.
3. Gordon HH: *Pseudomonas* infections. *Arch Dermatol* 109:261, 1974.
4. London ID: Buffered glutaraldehyde solution for warts. *Arch Dermatol* 104:96, 1971.

Allergic Reactions to Insect Bites and Stings of Fire Ants

To the Editor.—Again, this year I am compiling case reports of allergic reactions to bites by insects such as mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, and deerflies. I am also interested in reactions to stings of the imported and southern fire ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. The report should include the type of reaction and complications, if any; the age, sex, and race of the patient; the site of the bite(s); the season of the year; the immediate symptoms; the skin test results; desensitization results, if any; and any associated other allergies.

Send this information to Claude A. Frazier, MD, 4-C Doctors' Park, Asheville, NC 28801.

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Lentigo Maligna Associated With Porphyria Cutanea Tarda

To the Editor.—The simultaneous occurrence of uncommon diseases in a single patient is always fascinating, especially when the diseases are of dermatologic interest.

The following report depicts the association of porphyria cutanea tarda (PCT) with lentigo maligna. This is an association that has not been reported previously to my knowledge.

Report of a Case

A 56-year-old white man with a two-year history of vesicles and bullae on his forehead and dorsal hands was proved to have PCT by appropriate testing.

Examination also revealed an asympto-

matic 2-cm tan and brown, sharply margined, irregularly bordered macule on his right cheek, in an area uninvolved with the vesicles.

Biopsy bore out my clinical impression of lentigo maligna.

The case above demonstrates the simultaneous occurrence of two unusual entities in one patient.

GERALD GREENWALD, MD
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Polymorphous Light Eruption In Identical Twins

To the Editor.—Identical 25-year-old twin sisters from Michigan presented themselves in my office with their fourth attack of polymorphous light eruption during a period of four years. They had a profuse, pink papular rash confined to sun-exposed surfaces, which began on the third day of a vacation in Waikiki. Previous attacks had occurred in Nassau, Florida, and Acapulco; this was the first attack they had experienced when both were in the same resort, however.

There was no history of atopy, other skin problems, or recent medication. Time did not permit phototesting.

HARRY L. ARNOLD, Jr., MD
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ARCHIVES Format

To the Editor.—As an avid reader of the medical literature and especially that related to dermatology, I would like to suggest that the format of the ARCHIVES be adapted to that recently adopted by a sister journal, *JAMA*, ie, placing the Letters to the Editor and possibly the Society Transactions in the front of the journal.

My colleagues and I have found that many "pearls" of information are consistently found in these sections, and I think that they would be further appreciated when the reader is alert. This earlier reading of these sections would also "prime" the reader for the longer and more involved articles found later on in the journal.

I also think that more review articles are needed to match the caliber of the excellent ones the ARCHIVES has published in the past.

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