

(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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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.

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Occupational allergic contact dermatitis caused by acrylic tri-cure glass ionomer

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Case Report

A 30-year-old qualified dental nurse developed occupational fingertip dermatitis typical of allergic contact dermatitis caused by acrylate compounds (1). Her dermatitis healed during vacations but relapsed on re-exposure. She was daily exposed to light-cured hybrid-glass ionomers (3M Dental Products Division, MN, USA; Table 1, Fig. 1), bonding agents, dentin primers and dental composite resins. She suspected that the light-cured hybrid-glass ionomer caused her symptoms, because her dermatitis had started within months of this ionomer being adopted for use.

Patch testing revealed that she had become sensitized to several acrylics, including 2-hydroxyethylmethacrylate (2-HEMA; Table 2), a well-known contact sensitizer in

dental materials. Her hybrid-glass ionomer primer and liquid also provoked an allergic patch test reaction (++ , 1% pet.), but not the powder (Table 2). The standard series and non-acrylics in the dental screening series (1) were negative.

Table 1. Hazardous chemicals of light-cured hybrid-glass ionomer components according to material safety data sheet

<i>Vitremer® glass ionomer primer (3M Dental Products Division, USA)</i>	
2-hydroxyethyl methacrylate (CAS 868-77-9) (2-HEMA)	37-41%
ethyl alcohol	44-48%
polymer of polycarboxy acid	11-14%
<i>Vitremer® glass ionomer liquid (3M Dental Products Division, USA)</i>	
2-hydroxyethyl methacrylate (CAS 868-77-9) (2-HEMA)	18-20%
polymer of polycarboxy acid	50-55%
<i>Vitremer® glass ionomer powder (3M Dental Products Division, USA)</i>	
fluoroaluminosilicate (CAS 65997-17-3)	95-98%
methacryloxypropyltrimethoxysilane (CAS 2530-85-0)	2-4%
ascorbic acid (CAS 50-81-7)	<0.08%

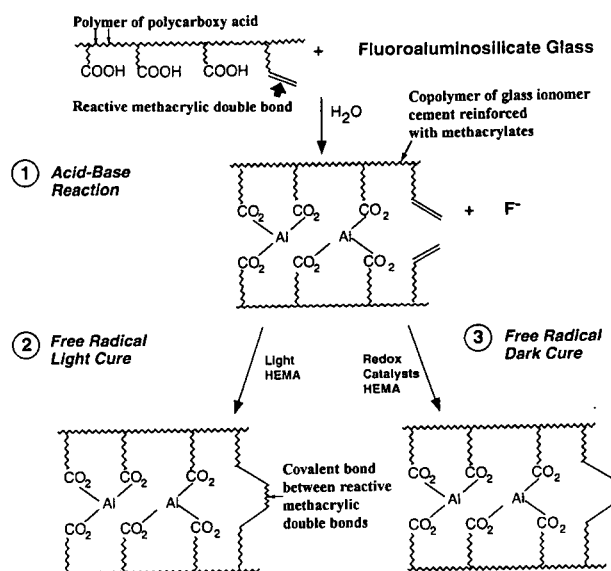


Fig. 1. Setting reactions of Vitremer® tri-cure glass ionomer, according to the manufacturer (3M Dental Products Division, MN, USA). Polymer of polycarboxy acid (a) in Vitremer® liquid reacts with fluoroaluminosilicate glass (b) in Vitremer® glass ionomer powder. Hardening takes place in a tri-cure reaction comprising an ① acid-base reaction, ② free radical light-cure reaction catalyzed by camphorquinone and a ③ free radical dark-cure reaction catalyzed by benzoyl peroxide. 2-hydroxyethyl methacrylate (HEMA) is added to the system to compensate water and is copolymerized to the acrylic polymer.

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