

- Contact allergy to moist toilet paper. *Contact Dermatitis* 1991; 24: 135.
4. Van Ginkel C J W, Rundervoort G J. Increasing incidence of contact allergy to the new preservative 1,2-dibromo-2,4-dicyanobutane (methylidibromoglutaronitrile). *Br J Dermatol* 1995; 132: 918-920.
 5. De Groot A C, De Cock P A J J M, Coenraads P J et al.

Methylidibromoglutaronitrile is an important contact allergen in The Netherlands. *Contact Dermatitis* 1996; 34: 118-120.

6. De Groot A C, Van Ginkel C J W, Weijland J W. Methylidibromoglutaronitrile (Euxyl K 400). An important "new" allergen in cosmetics. *J Am Acad Dermatol* 1996; 35: 743-747.

Contact sensitivity in women with anogenital dermatoses

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Key words: patch testing; vulva; perianal dermatoses; allergic contact dermatitis; medicaments; antibiotics; fragrance; local anaesthetics; corticosteroids. © Munksgaard, 1997.

Patients and Methods

201 women with anogenital dermatoses were referred to our contact dermatitis clinic over 14 years: 111 had a diagnosis of eczema, in 44 the diagnosis was unknown and in 46 the diagnosis was one of the following: psoriasis, lichen planus, vestibulitis or lichen sclerosus. 103 had a dermatosis only involving the vulva, 42 had perianal involvement only, and 56 had dermatoses involving both sites.

They were tested against the European standard series, a medicament series, a corticosteroid series and their own topical medicaments. Other specific allergens were tested where relevant. Patches were removed and read at 2 days and again at 4 days.

Results

79 (39%) of the 201 patients had 1 or more allergic reactions. Only 56 (28%) patients were found to have clinically relevant positive allergic reactions. The commonest types of relevant allergens are shown in Table 1.

19% of the patients with dermatoses only involving the vulva had a clinically relevant positive patch test (Table 2). This was significantly lower (χ^2) than those with dermatoses involving both sites ($p < 0.002$), but compared to the 33% who only had perianal dermatoses, the difference did not reach significance ($p < 0.07$).

Table 2. The % of patients with clinically relevant allergic reactions

Site of dermatosis	% of patients with clinically relevant positive allergic reactions
vulva	19
perianal skin	33
vulva and perianal skin	43

Reactions to local anaesthetics, tixocortol pivalate and antibiotics were commonest in patients with perianal dermatoses (Table 1).

Discussion

One large study of patients with vulval dermatoses has reported similarly low numbers of clinically relevant positive patch test reactions (1), whilst others have reported higher numbers (2, 3), but none have commented on the presence of perianal disease in their patients. Contact sensitivity is a common finding in patients with perianal dermatoses and pruritus ani (4). Vulval and perianal skin, though structurally and developmentally very similar, are functionally different. The vulval skin is exposed to foreign proteins during sexual intercourse and may therefore be more "resistant" to sensitization. Conversely, vulval skin has been shown to be very sus-

Table 1. The total number and % of patients with clinically relevant positive allergic reactions according to the site of their problem

Type of allergen	No. patients with allergic reactions	% of patients with positive reactions according to the site of their dermatosis		
		Vulval only	Perianal and vulval	Perianal only (42)
antibiotics	17 (including 15 to neomycin)	3	13	17
antifungals	5	3	4	0
antiseptics	4	1	5	2
perfume	15	7	5	12
local anaesthetics	17	3	9	21
preservatives	4	3	0	2
corticosteroids	13	2	9	14
miscellaneous (lanolin, Santolite resin)	2	1	5	0

ceptible to irritants (5, 6). This may lead patients not to apply their topical preparations to the vulval skin as liberally or as frequently as they do to the perianal skin. Patients with dermatoses extending to both the perianal and vulval skin may have more severe disease and consequently use more topical medicaments.

In view of the results of this study, patch testing is best performed in women with vulval dermatoses if the disease also involves the perianal skin.

References

1. Marren P, Wojnarowska F, Powell S. Allergic contact dermatitis and vulval dermatoses. *Br J Dermatol* 1992; 126: 52-56.
2. Lewis F M, Harrington C I, Gawkrödger D J. Contact sensitivity in pruritus vulvae: a common and manageable problem. *Contact Dermatitis* 1994; 31: 264-265.
3. Brennan J A, Dennerstein G J, Sfameni S F, Drinkwater P, Marin G, Scurry J P. Evaluation of patch testing in patients with chronic vulvar symptoms. *Aust J Dermatol* 1996; 37: 40-43.
4. Wilkinson J D, Hambly E M, Wilkinson D S. Comparison of patch test reactions in two adjacent areas of England. (II) Medicaments. *Acta Dermato-venereologica* 1980; 60: 245-249.
5. Britz M B, Maibach H I. Human cutaneous vulvar reactivity to irritants. *Contact Dermatitis* 1979; 5: 375-377.
6. Elsner P, Wilhelm D, Maibach H. Multiple parameter assessment of vulvar irritant contact dermatitis. *Contact Dermatitis* 1990; 23: 20-26.

Photosensitivity due to actarit

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A 52-year-old woman was seen in April 1996 with erythema and lichenification on sun-exposed areas (Fig. 1) that had started 2 months earlier. She had no past history of photosensitivity. She had been taking actarit (Mover[®], Nikken Chemicals Co. Ltd., Tokyo) 100 mg t.d.s. and doxycycline hydrochloride 100 mg t.d.s. orally because of rheumatoid arthritis and a chronic infectious ulcer of the right knee for 3 months. A rheumatoid arthritis test was positive (2+), while there were no other abnormal findings on hematological examination, blood chemistry, or urinalysis, including porphyrins of peripheral erythrocytes and urine. Histological findings of erythema on the dorsum of right hand demonstrated hydropic degeneration of the basal layer, slight intercellular edema, and dense perivascular lymphohistiocytic infiltration.

We performed a screening phototest, as described before (1), with a Dermaray Model M-DMR-1 (Eisai Co. Ltd.) as a light source (2, 3). UVB-MED for this patient was normal (70 mJ/cm²), while 6.75 J/cm² of UVA-irradiation, which was less than 13.5 J/cm², produced erythema on the irradiated area at 1 day after the irradiation. A screening phototest was performed again 2 months after she stopped taking the 2 drugs. Irradiation of 13.5 J/cm² for UVA elicited no response, suggesting that photosensitivity to UVA of the patient had become normal. Patch and photopatch tests were made with actarit and doxycycline hydrochloride (10, 1, and 0.1% pet.). Only 10% and 1% pet. of actarit with UVA-irradiation (4.5 J/cm²) on photopatch testing showed erythema 1 day after irradiation. Patch and photopatch tests with actarit and doxycycline hydrochloride in 5 normal subjects showed no erythema or papular re-



Fig. 1. Erythema and lichenification on the back of the hand.

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