

group were not patch tested (3) and patch testing in the 2nd report was inconclusive (4), though challenge with chewing gum resulted in recurrence of oral disease (4). Perioral dermatitis has also been reported in a child who chewed gum frequently (5), patch testing being positive to colophony, cobalt, fragrance mix, oakmoss and isoeugenol, as well as to chewing and bubble gums (5).

Colophony is a constituent of the gum base of chewing gum and is particularly found in Juicy Fruit® and Hubba Bubba® gums (personal communication, The Wrigley Company Limited®). Our 2 patients were both positive to colophony, supporting the rare association between contact allergy to colophony in chewing gum and oral disease.

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Oral lichen planus versus oral lichenoid eruption as a manifestation of contact allergy

M. PECEGUEIRO¹, M. F. SACHSE¹, J. AMARO¹, P. FARINHA² AND I. FONSECA²

¹Dermatology and ²Pathology Departments, Instituto Português de Oncologia, 1093 Lisboa, Portugal

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Last year, we saw a patient with an oral lichenoid eruption (OLE) of 10 years standing, due to allergy to mercury in dental fillings, replacement of which completely healed the lesions. We therefore decided to evaluate retrospectively 21 patients with oral lichen planus (OLP).

Patients and Methods

Among 21 patients with a clinical and histopathological diagnosis of OLP, 2 groups were identified: group A – 12 patients (5 female and 7 male) with metallic prostheses or dental fillings currently or in the past; Group B – 9 patients (3 female and 5 male) without such. Both groups included patients with acrylic prostheses. Clinical data are shown in Table 1, histopathological data in Table 2, and the results of patch testing with the

GPEDC standard series and dental screening series (Trolab and Chemotechnique) in Table 3. All biopsy specimens were reviewed blinded to the clinical background, 5 cases being rejected and no difference being found between the 2 groups. 3/12 patients in group A were mercury-positive, 2 in relation to dental fillings; 1 was allergic to chromium in a metal prosthesis. No relevant reactions were seen in group B.

Table 1. Clinical data

Clinical features	Group A (12 patients)	Group B (9 patients)
duration	8 m–10 y	1–11 y
symmetry	9	5
location:		
buccal mucosa	9	6
gingival mucosa	2	2
tongue	5	4
symptoms:		
burning	12	9
leukoplakia	9	4
erosion	0	4
acrylic prosthesis	6	6

Table 2. Histopathological data

Histopathological features	Group A (12 patients)	Group B (9 patients)
erosion	7/12	3/9
acanthosis	8/11	3/5
atrophy	3/11	2/5
granulosis	11/11	1/5
keratosis:		
ortho	4/11	5/5
para	7/11	2/5
degeneration	11/11	5/5
Civatte bodies	5/11	2/5
lymphoid infiltrate	11/11	5/5

Table 3. Patch test results

Allergen	Group A (12 patients)	Group B (9 patients)
ammoniated mercury	2 (1–R; 1–PR)	1 (NR)
metallic mercury	3 (2–R; 1–PR)	1 (NR)
potassium dichromate	1 (R)	–

R: relevant; PR: past-relevant; NR: non-relevant.

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

J. MURPHY, C. CLARK, K. KENICER AND C. GREEN

Department of Dermatology, Ninewells Hospital and Medical School, Dundee DD1 9SY, Scotland, UK

Key words: colophony; allergic contact dermatitis; Compositae; rosin; violinist; plants; musicians; occupational; gardening. © Munksgaard, 1999.

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 pompholyx-type hand dermatitis, as in our patient (4).

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