

pyogenes was the sole causative agent in only one patient.⁴ Although the determination of the causative agent can be difficult on clinical evaluation, important clues to the aetiology include patients' travel history, geographical area, contacts (human and animal), immune status, occupation and history of trauma, and illicit or recreational drug abuse. Also, a short incubation period (< 1 week), as in our patient, is suggestive of a pyogenic aetiology. The final diagnosis is often possible only on histopathological examination and culture (mycological, bacterial and viral).

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What is the role of surgery in the treatment of Kaposi's sarcoma?

Editor

In the January 2006 issue of the *JEADV*, Avalos-Peralta and colleagues report the case of a patient with pemphigus vulgaris who developed Kaposi's sarcoma (KS) lesions exclusively on a pemphigus vulgaris plaque previously treated with intralesional corticosteroids and who was treated with immunosuppressive agents.¹ The authors report that 'the lesions were excised with a large margin and then sutured'.¹ Although there is no doubt that local therapies have some role in the management of KS by providing effective treatment of individual KS lesions,² I am surprised that surgery with large margins was performed. This may be misleading. Surgery has the advantage of providing a histological diagnosis and may be considered, along with other available local therapies, for patients with limited numbers of cosmetically bothersome lesions. However, most models suggest that KS begins as an

inflammatory reactive HHV-8-driven polyclonal process, which appears to be more multifocal than metastatic.³ Accordingly, and as reported in this report,¹ regression of KS can happen spontaneously or when immune responses are restored.³ Supporting this hypothesis, histological data suggest that clinically uninvolved skin of KS patients may exhibit vascular abnormalities similar to those described in early KS lesions.^{4,5} There is thus little evidence that surgery with large margins is of any use in KS. Moreover, this therapeutic modality may occasionally be limited by Koebner's phenomenon displayed by KS.

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Urticaria and anaphylaxis to povidone in a paracetamol preparation

A 9-year-old boy with a known rhino-conjunctivitis to grass pollen reacted with a generalized urticaria, rhino-conjunctivitis and dyspnoea 30 min after he had taken a preparation containing paracetamol in the form of a mixture. He was taken to hospital and was treated with injection of epinephrine and betamethasone per os. He improved rapidly. He had previously reacted with pruritus and erythema when using a hair conditioner. He had also reacted to penicillin tablets and dental fluoride. Paracetamol

in a suppository had been given several times without any problem.

Povidone (polyvinylpyrrolidone, PVP) was the only common substance out of the constituents of the products he had reacted to. Prick tests were performed using physiological saline and histamine (10 mg/mL) as controls. After consulting the local pharmacy about the type of povidone used in medical products we tested with both povidone K25 and povidone K30. These products are both polymers consisting of linear N-vinyl-2-pyrrolidone groups, but of different degrees of polymerization, giving different average molecular weights. He reacted to both types of povidone in 0.001% concentration, with the same strength as for the standard histamine test.

Povidone is a polymer widely used in medical products and also in skin care products. It has been reported to give contact dermatitis in several patients but only a few reports on anaphylaxis can be found; most of these reports concern povidone-iodine as a local antiseptic.¹⁻³ Only one reaction after intra-articular injection has been reported,⁴ and two reports can be found after per os administration of tablets containing povidone.^{5,6} One of these relates to the first incidence of povidone-induced anaphylaxis in a child.⁶ Povidone has been reported to be a constituent of about 20% of the tablets used in Germany. In Sweden we found more than 1000 medical products with PVP. PVP is also a component in, for example, eye cosmetics, shaving gels, hair dressing products (spray, mousse, gel, etc.), laundry detergents and paints.

Allergic reactions have been reported to organic polymers. In one case report on PVP, Rönna *et al.* demonstrated specific serum IgE antibodies against povidone by using the dot blot technique.⁵ Also, a positive ELISA suggesting an allergic reaction has recently been reported.² Although only a small number of povidone-allergic patients has been reported we believe that the widespread use and the serious reactions of reported patients call for a more careful handling of this compound. It is remarkable that all reports have been published during the past 10 years considering that povidone has been used for a long time in many products. It may be that there are many misdiagnosed patients with allergic reactions to povidone.

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Milky nails

Editor

Leukonychia is the most common form of nail discoloration or dyschromia. Leukonychia (white nails) has been classified according to the distribution of the white colour as leukonychia punctata, leukonychia striata, leukonychia partialis, or leukonychia totalis.^{1,2} In addition, leukonychia can be divided into congenital (hereditary) and acquired forms, which can be true or apparent (pseudoleukonychia).

A 22-year-old man underwent routine medical evaluation for enlistment in the Hellenic Army. White finger nails on the digits on both hands were noted (fig. 1). He reported having white fingernails since birth. The patient took no



fig. 1 Leukonychia totalis (white finger nails).