Macular Amyloidosis, Notalgia paresthetica and Pruritus: Three Sides of the Same Coin?

J.D.

Bernhard

Worcester, Mass

J.D. Bernhard, MD, Division of Dermatology, University of Massachusetts Medical Center, Worcester, MA 01655 (USA)

Dear Sir

The picture of 'brownish macules showing a rippled surface' on the back of the patient with cutaneous amyloidosis reported by Barnadas et al. [1] is striking because the appearance, location and long history of localized pruritus are virtually identical to what is seen in notalgia paresthetica [2-4]. The latter – an abnormal and usually intensely pruritic sensation of the back – is thought to represent an isolated sensory neuropathy. Formerly considered uncommon, it has been reported under a variety of names in case reports over several decades. These include 'puzzling posterior pigmented pruritic patches', 'peculiar spotty pigmentation', 'hereditary localized pruritus' and, in one case which we reported and now recognize as probably the same thing, 'recurrent lichen simplex chronicus' [5].

One interpretation of the case presented by Barnadas et al. is that 20 years of itching and scratching played a causative role in the appearance of cutaneous amyloid deposits at the site on the back. This is certainly consistent with current theories which suggest that repeated friction or other trauma to the skin may lead to the deposition of significant amounts of degenerated keratin, which Hashimoto has proposed calling 'amyloid-K' [6-8]. One must wonder how many cases of macular amyloidosis of the back are in fact due to, or identical with, notalgia paresthetica. Recognition of this entity is important not only because correct diagnosis can prevent excessive diagnostic evaluation, but because treatment with topical capsaicin cream may be helpful in many cases [9].

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54

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The present observations suggest that neither circulating hGH nor IGF-1 play a significant role in the regulation of the SER in adult males.

G.B.E. Jemec, G. Kollerup, A. Kisling, J. Serup, 'Department of Internal Medicine, Sundby Hospital, and "Department of Dermatology, Bispebjerg Hospital Copenhagen (Denmark)

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Possible Influence of Growth Hormone on Sebum Excretion in Man

Sir,

The effects of pituitary hormones on the sebum excretion rate (SER) have been studied in states of hypopituitarism [1] and in patients suffering from acromegaly [2]. Data available suggest the presence of a pituitary sebotropic factor in man. Animal studies have shown that growth hormone (GH) is one possible such sebotropic factor, as GH can restore the response of the sebaceous glands to testosterone in hypophysectomised rats [3]. Since these studies were made, it has however become clear that the effects of GH are not due to a direct action of the hormone but rather to somatomedins or growth factors induced by GH. Little is known about the relationship of SER to human GH (hGH) or insulin-like growth factor 1 (IGF-1) in normal healthy volunteers. To study a possible relationship, hGH, IGF-1 and SER were studied in 8 healthy male volunteers, aged 24-38 years. The SER was measured using the Sebumeter SM420R (Schwartzhaupt, Cologne, FRG) which correlates well with other methods of measuring the SER [4,5]. It was measured in two symmetrical areas near the glabella, and the average value was used. The mean SER was 86.1 arbitrary units/h, with a range of 22.5-171 arbitrary units/h. Similarly the mean serum hGH was < 0.7 mIU/l, with a range of < 0.4-2.2 mIU/l. The mean IGF-1 was 127.9 ng/ml, with a range of 104-151 ng/ml. There was no significant correlation between the SER and hGH nor between the SER and IGF-1 (correlation: -0.1 and -0.2; $R^2 = 1.5 \times 10^{-2}$ and 0.1).

Chemical analysis was kindly provided by Kabi Vitrum, Sweden.

Clofazimine for

Residual Nodulocystic Acne Lesions

Patients affected by nodulocystic acne treated with isotretinoin, at the correct dose and during an adequate time, may present some residual suppurative fibrocystic nodules, principally on the

back of the neck. There are few therapeutic possibilities for such lesions. Local and systemic antibiotics do not help, radiotherapy gives only a transitory response and surgery, which necessitates a wide incision, leaves a very visible scar.

Recently 3 patients who presented this kind of residual suppurative fibrocystic nodule on the back of the neck have been treated with clofazimine. The results were spectacular, between 1 and 3 months after completed treatment. The patients were all male, aged 27, 22 and 24 years, and had a nodulocystic acne which had been treated by isotretinoin (0.5-0.75 mg/kg/day) for 5 months. They presented recurrence of acne 1 year later needing a second isotretinoin cycle at a dose of 1 mg/ kg/day for 3 months. On completing the second treatment the acne lesions were cured, but a residual suppurative focus persisted on the back of the neck. The residual nodule of the third patient was treated by radiotherapy (Siemens Dermopan II; total dose 600 cGy, 50 kV, 25 mA, FSD 15 cm, filter 1.0 Al) with only slight improvement.

The patients (weight 70 ± 5 kg) were given oral clofazimine 100 mg/ daily, two for 3 months, one for 7 months. The suppurative focus cleared. No side effects or skin pigmentation were seen. Some months after stopping clofazimine a discrete recurrence has been observed in the first and third patient, easily controlled by topical erythromycin