Nuchal Nevus flammeus and Alopecia areata

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Sir,

We read with interest the article recently published in your Journal [1] reporting on nuchal nevus flammeus (NNF) as a marker of prognosis in alopecia areata.

This study prompted us to examine for the presence of NNF 240 of our patients with alopecia areata, 126 females and 114 males, aged from 6 to 76 years ($x + SD = 24.66 + 14.2$ years) and 202 volunteers without

alopecia areata, 98 females and 104 males, aged from 3 to 76 years ($x + SD = 28.5 + 12.8$). We grouped them for sex, age, duration of the disease, clinical type according to Ikeda's [2] classification and we classified NNF into faint (+), medium (++) and marked (+ + +) since it varies in size and color [3]. Furthermore we studied the possible association between NNF and the presence of onychopathy, which is also considered a marker of the intensity of disease by some authors [4, 5].

In our study NNF was confirmed more frequently in alopecic patients (53 vs. 18.2% of controls younger than 14 years and 10.8% of normal adults); more precisely NNF was present in 71.3% of the patients with alopecia totalis or universalis and in 48% of the patients with patchy alopecia, but its presence was not related to sex, age, duration and clinical type, and faint, medium and marked NNF were not related with the severity of the disease.

Moreover NNF was more frequently associated with onychopathy (60 vs. 40%).

So the presence of NNF more than its appearance must be considered related to alopecia areata, especially that of severe degree.

The relationship between NNF and alopecia areata is an interesting matter for speculation. NNF could persist, instead of regressing with age as normally happens [6], in patients suffering or going to suffer from alopecia areata because of an altered scalp vasculature, whose involvement is also referred in this disease [7]. Moreover NNF is no more recognized as true angioma but as telangiectasia [8, 9] maybe, as already reported in portwine stains [10,11], with neurovascular alterations and with hypotonia of the supportive dermal elements. Furthermore anagen bulb has angiogenic properties [12] and the nape area, where NNF is located, is certainly a particular site: the sensitivity to topical allergens is higher [13], the anagen period longer and, probably for this [14], the hair regrowth more difficult.

For some of these reasons a relationship between NNF and alopecia areata must be taken into account and we hope that further investigations may reveal clues as to a possible link between these two phenomena.

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Letters to the Editor

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- Combination Therapy Ciclosporin-Etretinate Effective in Erythrodermic Psoriasis
- Sir,
- The effectiveness of ciclosporin (CS) in severe plaque psoriasis was shown in several studies [1-4] and in a case of generalized pustular psoriasis [5]. In 4 cases of erythrodermic psoriasis CS cleared the skin [6]. We present here a case of severe resistant erythrodermic psoriasis successfully treated with a combination of CS and etretinate.
- Case Report. A 50-year-old man had suffered from severe psoriasis for over 30 years. The psoriasis did not respond to local therapy or oral treatment with etretinate. There was only a mild response to PUVA therapy. During therapy frequent exacerbations of erythrodermic psoriasis occurred. The erythrodermic psoriasis cleared by 70-80% with methotrexate (15 mg orally once a week). Tapering off this dose resulted repeatedly in exacerbation of the psoriasis. After more than 20 years of PUVA therapy the patient developed a thin atrophic skin with multiple spinocellular carcinomas which were treated with cryosurgery. There was a serious risk of liver fibrosis and cirrhosis after a cumulative dose of 5.0 g methotrexate. An oral treatment with CS Sandimmune® (6.0 mg/kg/day) was started. Since the psoriasis did not respond to CS after 2

weeks of treatment, the dose was raised to 10.0 mg/kg/day. CS blood level with this dose was 300 ng/ml (HPLC method). During the following 4 weeks there was no response but serum creatinine was raised 50% of baseline. For this reason the CS dose was lowered to 5.0 mg/kg/day. Now etretinate (0.7 mg/kg/day) was started. Serum creatinine normalized and in the following month psoriasis cleared by 90%.

After 4 months of therapy with CS and etretinate, tapering off CS to 4.0 mg/kg/day resulted in an exacerbation of psoriasis within a week. After a raise of CS dose to 5.0 mg/kg/day psoriasis cleared again by 90%. A month later, the etretinate dose was lowered to 0.4 mg/kg/day, which resulted in an increase of psoriasis by 30% after 3 weeks. When the etretinate dose was again raised to 0.7 mg/kg/day psoriasis cleared by 90%. We concluded that CS and etretinate had an additive effect in the treatment of psoriasis.

Ten months after treatment with CS and etretinate no side effects have occurred except for a mild hypertension due to CS which could be controlled by administration of nifedipine.

Comments. Erythrodermic psoriasis is a severe form of psoriasis. A higher dose CS than for plaque form psoriasis is probably needed. A dose of CS higher than 5.0 mg/kg/day can impair renal function within a relatively short time. Long-term treatment may be possible with a lower dose of CS in combination with another treatment, e.g. PUVA [6] or etretinate. We showed that etretinate and CS may have an additive effect in clearing psoriasis.

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