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We hope that making available the relevant information on Pachyonychia Congenita will be a means of furthering research to find effective therapies and a cure for PC.
paper had been revised in the light of comments by a referee. We also failed to pick up errors in line 6 of the summary and in line 40 on page 13. At both points the printed ‘inflammation’ should have been ‘itch’, which answers point 4.

During the review process a referee specifically requested that non-parametric statistics should be used. The full details are shown in Table 1. It is on this table that the text was based and we should have revised Figure 1 in accordance with it.

The main point being made by Professor Greaves and Dr Corbett seems to be that the differences between the Efamol, evening primrose oil (EPO) and placebo groups are marginal and of doubtful clinical importance. We take a different view on the following grounds: (1) For all six clinical parameters assessed, EPO produced a significant improvement over baseline; for four of the six the \( P \) value was 0.01 or less. Placebo produced significant improvements over baseline in only two of the six parameters. (2) For every clinical parameter, except inflammation, the difference between the response to EPO and to placebo was in favour of EPO. This difference reached significance in the case of itch and came close to it for the area of skin involved. (3) Use of topical steroids in the EPO group was only 30% of that in the placebo group. This difference between the groups was significant. Therefore, the clinical improvements on EPO were achieved in spite of sharply reduced steroid use. (4) For five of the six clinical parameters, the differences between the EPO and placebo groups were greater at 12 weeks than at 6 weeks. It is, therefore, untrue to say that the differences between the two groups could simply be accounted for by more rapid improvement in the EPO group.

The consistent responses of all parameters to EPO, the consistent differences (especially with regard to itch) between responses to EPO and placebo, the reduction in topical steroid use in the EPO group to less than a third of that in the placebo group and the increasing differences between EPO and placebo as the trial progressed, all indicate that EPO was having a clinically important as well as a statistically significant effect. Finally, we would point out that the biochemical rationale for using EPO has recently been strengthened by an independent study which indicated, on the basis of measurements in umbilical cord blood and in atopic children, that the metabolism of linoleic acid is indeed impaired in atopic eczema.1

Department of Dermatology,
University of Turku,
SF-20520 Turku 52,
Finland
*Efamol Ltd,
Woodbridge Meadows,
Guildford, Surrey GU1 1BA, U.K.

C.T. JANSSEN
P. MORSE*

REFERENCE


Control of plantar blisters in pachyonychia congenita with topical aluminium chloride

MADAM, The letter from Drs Soyuer and Candan (British Journal of Dermatology, 1987, 117:264), concerning the disappointing results obtained with the use of etretinate to treat the palmoplantar keratoderma of pachyonychia congenita, has prompted us to report a simple, but quite effective, remedy for the pedal blistering frequently suffered by those with this condition. The blisters in pachyonychia congenita form within the stratum spinosum (personal observation) and are histologically indistinguishable from normal friction blisters. Hyperhidrosis, which is a usual feature of pachyonychia congenita, is known to increase the proclivity to blisters by influencing the coefficient of friction of the skin, and this fact provided the rationale for the use of a topical antiperspirant in a 25-year-old female with the
Correspondence

Jadassohn-Lewandowsky variant of pachyonychia congenita. Since childhood the patient had developed painful blisters on the soles of her feet after minimal exercise, particularly during the summer months. However, within a few weeks of applying 20% aluminium chloride hexahydrate in alcoholic solution to her soles night and morning, she noticed a diminution of the hyperhidrosis concomitant with an appreciable reduction in the tendency to form blisters, which persisted with the continued use of the antiperspirant. Topical aluminium chloride has also been used successfully to control blistering in the Weber-Cockayne type of epidermolysis bullosa simplex, and the simple expedient of reducing sweat production may ameliorate a distressing symptom of otherwise untreatable genodermatoses.

Department of Dermatology,
Guy's Hospital,
St Thomas Street, London SE1 9RT, U.K.

M.J. TIDMAN
R.S. WELLS

REFERENCES


Mepacrine and pregnancy

MADAM, We wish to report the successful outcome of two consecutive pregnancies in a patient who took mepacrine 100 mg daily for the first 4 weeks of each gestation period. Mepacrine had been prescribed for the treatment of discoid lupus erythematosus and the patient advised against becoming pregnant whilst taking the drug. On both occasions she stopped taking mepacrine as soon as she suspected that she was pregnant.

Eight nerve damage, posterior column defects, mental retardation, neonatal convulsions and retinal damage have all been reported in association with maternal ingestion of chloroquine during pregnancy. However, there is little useful information regarding mepacrine, despite its extensive use in the treatment and prophylaxis of malaria. One animal study has shown an increased incidence of fetal death with high doses of mepacrine in rats. There is also a case report of renal agenesis and hydrocephalus occurring in a human infant whose mother took mepacrine 100 mg daily for the first 2 weeks of pregnancy, however, it is questionable whether these abnormalities were related to ingestion of the drug in this case as organogenesis takes place later in gestation and the fetus is thought to be more ‘resistant’ to such insults during the first few weeks of development.

Our patient’s two children, now aged 3 years and 4 months, respectively are both normal. The older child had a brief systolic murmer noted at birth which subsequently became inaudible. Whilst we would not advise the use of mepacrine during pregnancy this information may be of use in the future should other patients inadvertently become pregnant whilst taking this drug.

University Department of Dermatology,
Royal Victoria Infirmary,
Newcastle upon Tyne NE1 4LP, U.K.

FRANCES HUMPHREYS
JANET M. MARKS

REFERENCES