Pseudoxanthoma elasticum-like skin changes induced by penicillamine

From Dr Barry Bentley-Phillips
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Sir, The report by Meyrick Thomas *et al.* (September 1984 *Journal*, p 794) described a male patient suffering from cystinuria. He had been treated with oral D-penicillamine in large doses (2.5–3 g daily) for 14 years and had developed penicillamine dermopathy. In addition to the recognized side effects of this drug (haemorrhagic blisters, elastosis perforans serpiginosa and cutis hyperelastica), he had produced lesions clinically indistinguishable from pseudoxanthoma elasticum (PXE). After extensive and sophisticated investigations the authors concluded that the PXE was a previously undescribed side effect of the drug.

The report brought to mind a young Indian girl I saw in 1978 who was suffering from Wilson's disease, well controlled by large doses of the copper chelating agent D-penicillamine (900 mg/day for 14 years). She had also developed typical PXE, which I then regarded as two rarities in one patient. The possibility of the PXE being related to the intake of D-penicillamine had not occurred to me. I therefore arranged to see my patient again (6 years after my original examination), now aged 19, with extensive cutaneous lesions. The PXE has spread and the 'plucked chicken' appearance is well shown in Figure 1. She also shows cutis elastica, particularly over the abdomen (Figure 2) and elastosis perforans serpiginosa (warty papules). There are also haemorrhagic blisters over pressure points, particularly the knees (Figure 3) with milia.

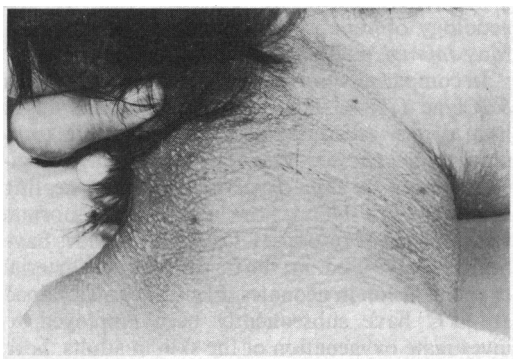

Figure 1. 'Plucked chicken' neck of PXE

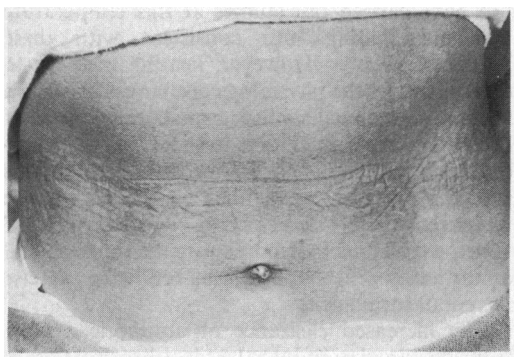

Figure 2. Cutis elastica of abdomen

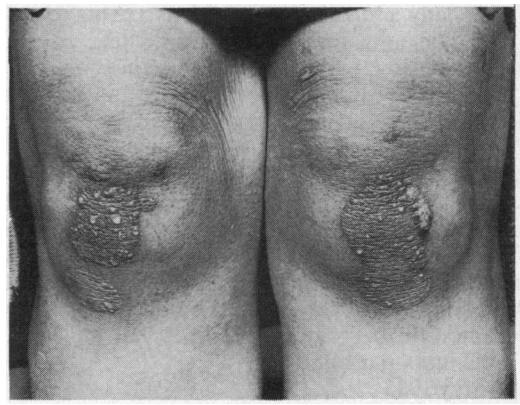

Figure 3. Lesions over knees showing milia

In retrospect it would appear that the PXE is due to the drug, and that my original diagnosis of two rarities occurring simultaneously in the same patient was incorrect. My case would be the second to be described if that of Meyrick Thomas *et al.* was indeed the first. Whether withdrawal of the D-penicillamine and substitution of some other chelating agent would produce a reversal of the cutaneous effects in my patient must await future studies.

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Erythema multiforme associated with menstruation

From Dr Katharina Dalton
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Sir, Dr Wojnarowska and colleagues (May *Journal*, p 407) seem to have missed the first reported case of premenstrually-recurring erythema multiforme – a married factory worker, aged 49 years, who was one of a series of 86 cases of premenstrual syndrome (Greene & Dalton 1953); the diagnosis of erythema multiforme had been made by a consultant at St John's Hospital for Diseases of the Skin, London. Her history was also discussed and a slide shown at a meeting on the premenstrual syndrome held by the RSM's Section of General Practice in November 1954 (Dalton 1955). Wojnarowska's case comes within the definition of premenstrual syndrome, which is the 'presence of recurrent symptoms before menstruation with *complete absence of symptoms after menstruation*'. My patient did not have a history of previous oral contraception. Treatment