Section of Dermatology

President Brian F Russell MD

Meeting November 21 1968

Cases

Allergic Vasculitis (Tri-symptom of Gougerot) Treated with Dapsone

G C Wells FRCP
(*St Thomas's Hospital, London*)

Mrs J K, clerk, aged 41

History: Persistently recurring purpura for ten years. General health has been good and there has been no indication of systemic disease apart from occasional nose bleeds. She has been continuously under observation since 1959 and was shown at a meeting of this Section in March 1962. Recurrences of the eruption are preceded by tingling, and crops of purpuric papules a few mm in diameter are scattered symmetrically on the feet and legs (Fig 1, January 1962). Often there have been vesicular, pustular or necrotic elements in some of the lesions. Persistent plaques have gradually been built up on ankles, knees and elbows with clinical resemblance to erythema elevatum diutinum (Fig 2, January 1967). Several skin biopsies have been made and some of them show leukoclastic angiitis. ENT specialists have at times found crusting high up in the nose, but no identifiable pathology.

Investigations: Afebrile whilst in hospital during three admissions. X-rays of chest and sinuses showed no abnormality. Repeatedly normal or negative: urine tests, blood counts, platelet counts, ESR, LE cells, antinuclear factor, anti-

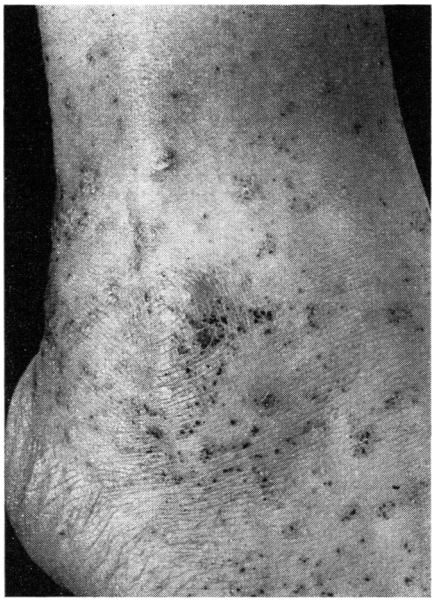

Fig 1 *Allergic vasculitis with recurrent papules and purpura*

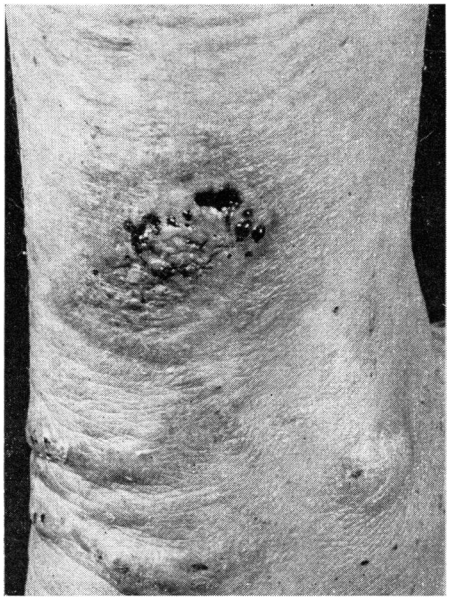

Fig 2 *Allergic vasculitis with persistent granulomatous plaques*

streptolysin titre, serum proteins and electrophoresis, agglutinations (Widal and brucella groups), fibrinolytic activity, Mantoux reaction.

Treatment: For the first time in ten years lesions cleared completely when she was given dapsone in January 1968. On 50 to 100 mg daily she has remained clear of lesions over the past ten months apart from a minor relapse when dapsone was stopped for one month. The giving of dapsone was prompted by the report of Vollum (1968) concerning its effect in atypical erythema elevatum diutinum, which shows histological evidence of small vessel angiitis.

REFERENCE
Vollum D I (1968) *Brit. J. Derm.* **80**, 178

The President: In the granulomatous form of allergic vasculitis the histological evidence of vasculitis may be very slight. Is this because the granulomatous process obliterates vessels?

Dr G C Wells: In the granulomatous or scarred lesions of allergic vasculitis the histological appearance of leukocytoclastic angiitis may have been obliterated. In only two out of five biopsies made in this case was the diagnostic histological appearance present.

Management of Pemphigus Vulgaris during Pregnancy

G C Wells FRCP and R M Ballard MB
(*St Thomas's Hospital, London*)

Mrs S R, aged 24, housewife

First seen in March 1968 with extensive soreness of the mouth and lips. Her previous health had been good.

Erosive gingivitis had been present for at least eighteen months. Since October 1967 she had been treated with prednisone 15 mg daily at a dental hospital for what was then thought to be erythema multiforme. The prednisone was stopped in December 1967 because she had become pregnant. Since then the erosive stomatitis had gradually spread in spite of using topical corticosteroids.

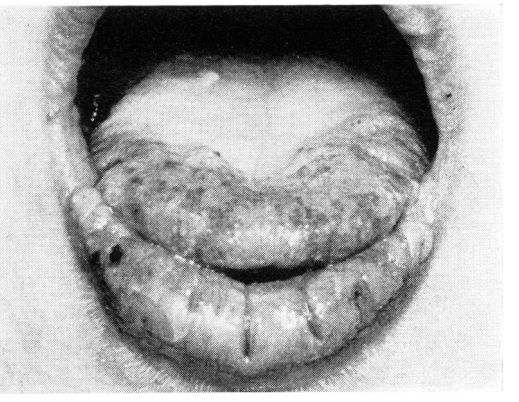

Fig 1 *Persistent erosions of the mouth and lips in pemphigus vulgaris*

When admitted to St Thomas's Hospital in April 1968 her buccal mucosa and tongue showed widespread shallow ulceration and the lower lip was fissured, crusted and bleeding (Fig 1). There were flaccid blisters on the abdomen and a few small blisters on the ankles. Smears from these blisters and from mouth lesions showed extensive acantholysis diagnostic of pemphigus vulgaris. Professor Philip Rhodes found a normal 28-week intrauterine pregnancy and general medical examination was normal. It was decided to give sufficient prednisone to control the pemphigus.

The antenatal period was uneventful and she was admitted on July 12, 1968, at 39 weeks, in early labour. A normal class A male infant weighing 3·5 kg was born spontaneously the following day. The patient and baby were discharged on the twelfth day after a normal puerperium. Although the adrenal function of the neonate was not assessed, serum electrolytes and the clinical state were normal and there were no signs of adrenal insufficiency.

Twenty-four-hour collections of maternal urine were analysed for pregnanediol content during the last ten weeks of pregnancy (Table 1).

Comment

Pregnanediol is a breakdown product of progesterone and its level in the maternal urine gives a

Table 1
Changes in urinary œstriol/pregnanediol output with oral prednisone

Weeks of pregnancy	30	31	32	33	34	35	36	37	38	39
Urinary œstriol (mg/24 h)	7·7	7·7	4·2	4·6	3·9	3·7		4·5	3·8	12·5
Urinary pregnanediol (mg/24 h)	25·8	28·2	29·2	29·2	18·0	44·8		39·6	49·6	25·8
Oral prednisone (mg daily)	0	100	100	80	80	60	45	45	45	45