Authors’ reply

Sir,

First of all I appreciate the efforts and the hard work put in by my critic to bring about certain points regarding my article titled “Many faces of cutaneous leishmaniasis.” Here is my reply regarding the comments raised.

1. Figure 5, as pointed out in the letter, was contributed by the second author of my article and she was also the coauthor of the article published in the British Journal of Dermatology. Thus, there is no question of plagiarism.

2. Authors were duly credited in both the articles according to authorship criteria.

3. It must be understood that collecting data and authorship are two entirely different issues. For collecting data, all authors need not be present simultaneously at the same place. There was no second author in the article published from Sierra Leone. The name of the second author appeared due to a printing error by the publisher of the journal. (I have already intimated this error to the editor of the concerned journal and he has apologized for the omission and pledged to publish an “erratum” in the forthcoming issue.)

4. The above-mentioned point appropriately clarifies all the ambiguities and doubts raised by my critic regarding simultaneous conduction of studies by two authors at three different centers.

5. There is no duplication of either title or contents of previously published data/article. The article titled “Morphological patterns of cutaneous leishmaniasis seen in Pakistan” was more about morphological patterns of typical cases of cutaneous leishmaniasis from all four provinces of Pakistan and the present study was basically aimed to encompass the unusual clinical spectrum from some geographically restricted areas and to highlight few emerging atypical faces of the disease.

Arfan Ul Bari, Simeen Ber Rahman

Department of Dermatology, Combined Military Hospital, Muzaffarabad, AJK, Pakistan. 1Military Hospital, Rawalpindi, Pakistan

Address for correspondence: Maj. Dr. Arfan ul Bari, Consultant Dermatologist, Combined Military Hospital, Muzaffarabad, AJK, Pakistan. E-mail: albariul@yahoo.com

DOI: 10.4103/0378-6323.48669

Dexamethasone–cyclophosphamide pulse therapy in pemphigus

Sir,

Pemphigus vulgaris is a potentially fatal disease in spite of a variety of treatment modalities available. The
The introduction of dexamethasone-cyclophosphamide pulse (DCP) therapy for the pemphigus group of disorders by Pasricha et al. in 1981 has revolutionized the therapy of pemphigus. The standard DCP therapy had also been given to our patients for the last 5 years and the results are as reported below.

Twenty patients of pemphigus admitted at the SKIMS Medical College Hospital, Srinagar were enrolled for the study prospectively from May 2001 to April 2006. Diagnosis of pemphigus was based on clinical features, Tzanck smear and skin biopsy. Confirmation was carried out by direct immunofluorescence examination. DCP therapy was given to those patients with positive Tzanck smear and histopathological features of pemphigus. Before starting the pulse therapy, investigations undertaken were — complete hemogram, erythrocyte sedimentation rate (ESR), urine analysis, blood sugar, kidney and liver function tests, chest radiography, electrocardiogram and stool examination for occult blood. Two patients had hypertension, one had diabetes and one had associated vitiligo. All investigations were repeated at monthly intervals and when necessary. The patients were monitored for side effects of DCP therapy.

The entire treatment was divided into four phases as per Pasricha et al. schedule. Phase I: DCP therapy was given in the presence of signs and symptoms. Patients received monthly doses of 100 mg of dexamethasone dissolved in 500 mL of 5% dextrose by slow intravenous infusion over 2 hour on three consecutive days along with 500 mg of cyclophosphamide in the infusion on day 2. In between, the patients received 50 mg of oral cyclophosphamide daily.

Phase II: Patients were in remission but monthly DCP therapy and daily oral cyclophosphamide were continued for 9 months.

Phase III: Only oral cyclophosphamide 50 mg was given to patients for an additional 9 months.

Phase IV: All treatments were withdrawn and patients were followed-up for relapse, if any.

Of the 20 patients of pemphigus vulgaris treated with this regimen, there were nine males and 11 females, the age ranged between 32 and 60 years. One unmarried male and one female who had not completed her family were given dexamethasone pulse (DP) without cyclophosphamide infusion but with daily oral cyclophosphamide. The duration of disease before treatment varied from a minimum of 1 month to a maximum of 7 years. Only six patients were treated with various other modalities before entering the study. Two patients were lost to follow-up. Of the remaining 18 patients, eight are in phase IV, six in phase III and four in phase II. The duration of phase I varied among patients, mostly being 3–4 months, with no correlation with age and sex of patients or the severity of the disease at presentation. Only two patients required daily oral corticosteroids in the first phase and none was given interval pulse. No case of death was seen amongst the cases studied. The duration of continuous remission in the patients is more than 2 years, the maximum being 5 years.

The side effects associated with prolonged treatment with corticosteroids and cyclophosphamide were virtually absent. The common side effects seen were generalized weakness and fatigue (7), gastrointestinal symptoms (5), menstrual irregularities (5), alopecia (4), candidiasis (2), dermatophytosis (1), hypertension (1) and urinary symptoms (1). No significant changes in laboratory parameters were seen.

Pemphigus is an autoimmune bullous dermatosis having a grave prognosis and is associated with high morbidity and mortality. Systemic steroids and other immunosuppressive therapies have remained the mainstay of treatment of pemphigus. DCP therapy designed by Pasricha Gupta for pemphigus and was first used in 1981 with the aim of reducing the toxicity of corticosteroids and also to achieve better therapeutic results. Since then, the same pulse therapy has been used and complete remission of pemphigus has been reported. In addition, the therapy also reportedly leads to a significant decrease in the mortality rate associated with the disease and there is a remarkable decrease in the side effects associated with long-term use of steroids and immunosuppressant drugs. Our study included 20 patients of pemphigus vulgaris, of which eight are already in phase IV and others in different phases also showed remarkable response. The side effects profile was comparable with those from previous studies.
Halobetasol versus clobetasol: A study of potency

Sir,

Topical corticosteroids (TCS) are an integral part of dermatological therapeutics. The clinical effects of TCS depend on the structure of the molecule, the vehicle and the skin onto which it is applied.[1] Addition of a fluorine molecule at six and/or nine positions enhances the potency of TCS. Halobetasol propionate has 6α-fluoroclobetasol 17-propionate as the active ingredient. Very occlusive vehicles enhance TCS molecule percutaneous absorption probably by increasing the hydration of the stratum corneum.[2] To estimate potency, various assays like vasoconstrictor assay and artificially induced inflammation using ultraviolet light can be used.[1] The ability of TCS to inhibit the size of histamine-induced wheal was used to assess the relative efficacy of halobetasol propionate and clobetasol 17-propionate in cream and ointment formulations in an open-labeled study conducted on 30 volunteers.

Thirty volunteers who had not used systemic, topical corticosteroids or antihistamines for at least 8 weeks and not on any other drugs for at least 7 days were studied. Pregnant and lactating females, individuals with history of any atopy, systemic disease or skin infection were excluded from the study. A template with five apertures (3 cm × 3 cm) cut 2 cm apart was placed on the left forearm and, with a marker pen, each aperture was outlined. The squares were numbered 1, 2, 3, 4 and 5. The first aperture was left free. A half fingertip unit each of halobetasol ointment and cream and clobetasol ointment and cream was applied over apertures 2, 3, 4 and 5, respectively [Figure 1]. The first square and steroid preparations on all the other squares were wiped after 3 h with a dry gauze piece. Prick testing was performed on all squares by the standard method. A drop of 0.1% w/v histamine solution was placed on the test sites and the skin was pricked through the histamine solution with a lancet. The tip was kept parallel to the skin surface and the skin was lifted by tenting the lancet by 45–60°. After 1 min, the test sites were dabbed with filter paper to remove excess histamine solution. The size of the wheal was recorded in millimeters after 15 min and the mean size was calculated by measuring the maximum diameter and the orthogonal diameter of the wheal with a transparent scale. Similarly, prick testing was carried out after 24 h.

The mean diameter of the wheal after 3 and 24 h is shown in Table 1. Post hoc analysis showed that at 3 h there was a statistically significant difference in wheal suppression between clobetasol cream and

![Figure 1: Forearm with template](image)

Letters to the Editor

Sheikh Manzoor, Yasmeen Bhat, Shabir Ahmad, Andleeb, Inam

Department of Dermatology, STD and Leprosy, SKIMS Medical College Hospital, Srinagar, India

Address for correspondence:
Dr. Yasmeen J Bhat, Department of Dermatology, STD and Leprosy, SKIMS Medical College Hospital, Bemina, Srinagar, Jammu and Kashmir, India.
E-mail: yasmeen_bhat2001@yahoo.co.in

DOI: 10.4103/0378-6323.48671 - PMID: 19293511

REFERENCES