Grafting and PUVA was interesting (J Am Acad Dermatol 1995;32:943-8). We have treated 10 cases of vitiligo of the lip, which have been static for 1 year or more, with suction blister grafting.

All patients were exposed to 15 J/cm² of UVA 5 minutes after application of 0.75% methoxsalen solution on the day before surgery. In many of these patients we have been able to remove the erythematous friable blistered skin with a dry gauze before blister grafting. In some patients we have had to use dermabrasion with a motor-driven burr to remove the vitiliginous skin. We have not used liquid nitrogen for the recipient area.

After grafting, in six cases the epidermal graft became detached after 7 to 10 days. However, pigmentation was noted in all cases after PUVA treatment. We believe that basal cells, including melanocytes, may remain in the grafted area while the upper portion is being shed. Histopathologic examination may confirm this hypothesis, but may not always be feasible. The possible beneficial effect of removal of the depigmented skin without grafting followed by PUVA may also be considered.

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Topical calcipotriene ointment and etretinate: Another combination therapy for psoriasis vulgaris

To the Editor: We read with interest the “Proceedings of the Psoriasis Combination and Rotation Therapy Conference” in the February 1996 issue of the Journal (1996;34:315-21). We have experience with a new combination therapy not reported in their article: calcipotriene ointment and etretinate. We compared the effects of two topical treatments (calcipotriene ointment vs petrolatum) used with oral etretinate (0.5 mg/kg) in 25 patients with chronic plaque-type psoriasis vulgaris. The study period was 10 weeks. A localized open right/left trial was used. We evaluated opposite symmetric areas on the forearms of each patient. Patients were examined at baseline and every 2 weeks.

Twenty patients completed the study, but only two withdrew because of adverse events. All adverse events involved the skin (irritant reactions with calcipotriene), and no systemic or biochemical abnormalities were detected in any of the patients. At the end of the study our mean severity score was 0.93 on the calcipotriene-treated side and 1.76 on the petrolatum-treated side (p < 0.0001). Thus it appears that calcipotriene ointment may increase the response of psoriasis to etretinate and could have a place in combination and rotational therapies, although blind-blind studies are required to evaluate it further.

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Reply

To the Editor: We appreciate the comments of Shenoi and colleagues; we would like to elaborate on their opinions. The removal of recipient vitiliginous skin can be accomplished by cryotherapy with liquid nitrogen, topical PUVA, dermabrasion, or resurfacing lasers. However, from our experience we have found that cryotherapy produces even intact blisters and that these results are repeatable. The other three modalities are not as dependable, and results with dermabrasion or laser resurfacing rely heavily on the expertise of the clinician. The beneficial effect of removal of depigmented skin without grafting followed by PUVA is minimal at best. We have tried this therapy before, and the results were disappointing. In our clinic, we frequently witness repigmentation when epidermal grafts become detached after only 2 or 3 days. Thus we believe that 7 to 10 days is sufficient for the transfer of melanocytes to the recipient skin.

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Reply

To the Editor: This study by Vázquez-Lopez, Pérez-Oliva, and Hernandez-Mejia is interesting and has potentially important clinical implications. The epidermis has both retinoid and vitamin D (dovonoid) receptors, each of which has a role to play in diseases such as psoriasis. It would be important to ascertain, in a larger double-blind study, whether the use of adjunctive topical calcipotriene allows one to clear, as well as maintain clearance of, psoriasis with lower dosages of etretinate. The only concern would be the potential for increasing the cutaneous irritancy inherent in both of these agents.

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