Correspondence/Brieuwerubriek

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Die mening gelui in die Brieuwerubriek van die SAAMJ nie nodwendig die van die Mediese Vereniging van Suid-Afrika nie.—Redakteur

As rookdampies trek oor ons land...

Aan die Redakteur: Na 'n dieptestudie oor 'n baie lang tydperk het ek tot die onteemseglike gevolgtrekking gekom dat die sterrfesfer in direkte verhouding tot die geboertesfer staan. Daar sal nie meer mense sterv as wat gebore word nie, of anders gestel: net daardie mense wat wel gebore is, sal ook sterwe. Is dit dan nodig om aan te hou mors oor toevallige hydraande oorsake?

Rome staan in ligtelaeie —
almal vlug, mense, honde, hoenders, kraai.
Nero dink: Tot bedaring bring ek vir hulle flus
vioolmuisiek sal selfs vir skoonma sus ...

As rookdampies trek oor ons land, onstaan polemiek van alle kant (ja, selfs van Alkantrant).
Settele et al. braak gal:
Met wetgewing sal ons hul dwing
en so ontsoeedel ons die omgewing.
Hertzog, Malherbe en hul travante
maan: Elke saak het vele kante.
Die een wat alle plesiertjies wil beheer
sal in ons land nie lank regeer.
Onthou: Sterfse se vermanme oorsaak
is toe te skryf aan mensies maak.
Ontnem die volk nou die plesier
Kort, broer, kort is dan jou uur ...

Met apologie en sonder kwaadwilligheid aan genoemde name!

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A new treatment for psoriasis

To the Editor: About 80 million people suffer from psoriasis, a disease which is singularly resistant to therapy. Since psoriasis has an inherited element, the aim is to control the lesions and obtain a good responsive and resting phase.

Many attempts at local treatment have been made, with the aim of restraining excessive epidermal cell replication by interfering with nucleic acid synthesis, but problems have arisen because of the toxicity of some relatively effective drugs. At present the most popular but still controversial treatment is PUVA, in which methoxypsoralen is given 2 hours before irradiation with long-wave ultraviolet light. The beneficial results are presumably due to the DNA binding to the DNA of the epidermal cells. Systemic drugs, of which the most effective is methotrexate, have also been used.

While using diet and thyroxine in obese patients with psoriasis, I found it interesting that the psoriasis responded quite dramatically, and was encouraged to follow up this association. The role of the thyroid is further suggested by the fact that psoriasis gets worse in patients on lithium treatment for depression; lithium induces hypothyroidism and also inhibits cyclic adenosine monophosphate (cAMP), causing cell proliferation. One patient with psoriasis who underwent thyroidectomy experienced a flare-up of her skin lesions until her postoperative dose of thyroxine was stepped up.

Since a number of factors are known to trigger off psoriasis, my approach has been to look for these factors and if possible eliminate them, to use thyroid hormone in increasing doses systematically with β-blockers and essential phospholipids (EPLs), and finally to add topical steroid creams only when the lesions have not cleared completely. Skin lesions treated with steroid ointments became highly sensitive and subsided into a resting phase, even in patients who had previously been steroid-resistant (it must be remembered that topical steroids are merely a secondary line of treatment and used to produce a good cosmetic result).

This approach has now been used on 200 patients. I am sufficiently encouraged by the results to publish them in the hope that others may confirm and perhaps elucidate the mechanisms behind them — the importance of hydrolyte reductase, cAMP and the cell membrane factor, and their possible effect on the DNA factor. Common triggers in psoriasis are of course obesity, hyperlipidaemia, infections (especially with Streptococcus haemolyticus), trauma (physical and stress), and silent diseases.

During the past 5 years, in addition to routine blood chemical analyses in every case, HLA antigens have been investigated at the South African Institute for Medical Research, since HLA tests may prove of value in treating psoriasis.

Patients are cautioned against the use of certain drugs which may aggravate psoriasis, such as sulphonamides, thiazides or sulphonylureas. EPLs given in a vitamin supplement are used, since one factor in psoriasis is thought to be a disorder of cell membrane permeability and EPLs are believed to assist optimal cell membrane permeability and ion transport.

Thyroxine, with the action controlled by a β-blocker (propranolol 10 mg/d), is given in a dose of 100 mg/d for the first 4 - 5 days, after which the dose is increased to twice daily. At 5 - 7-day intervals the thyroxine dosage is increased by 100 mg/d until an optimal dose of about 400 - 500 mg/d is reached, with the propranolol dosage also increased to control blood pressure and pulse rate. Patients should be examined biweekly to adjust dosages and note the skin response.

In approximately 5 - 6 weeks at a dosage of 400 - 500 mg thyroxine a marked improvement can be observed — there is reduction of exfoliation and flattening of lesions, pruriitus has disappeared or is much improved, and haloes are forming around lesions or in the centre. Patients with stable psoriasis and large plaques may prove more resistant and improvement will take longer. The skin now becomes highly sensitive to topical steroids, and huge plaques will clear.

After a few months of control, dosages can be reduced and maintenance therapy continued. Topical steroids can be slowly reduced so as to achieve the maximum result with the minimum application. Good control and responsive and resting phases for long periods are achieved.

This therapy has proved most effective in controlling seronegative, obitate, chronic psoriatic arthropathies. Results in some of the more severe cases have been as follows: 9 patients with arthropathies of fingers and toes (duration of disease 10 - 30 years, period of treatment 6 months - 2 years) have had good and very good results. Most are on maintenance therapy and there have been no relapses. Six patients had palmar and planter lesions; in 5 (duration of disease 2 - 30 years, period of treatment 6 months - 2 years) there was an average of 80% improvement and no significant relapses. The 6th (duration of disease 4 years), who had gross psoriasis — all the fingers and joints of both hands were stiff and no flexion was possible — has a 70% skin result and flexion is now completely normal. The balance of the patients treated, mainly between 1978 and 1981, all had mixed types of psoriasis involving various parts of the body and scalp; once again good results were achieved compared with other methods of treatment.

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Fetal abnormality associated with the use of captopril during pregnancy

To the Editor: We wish to report what we believe to be the first described case of fetal abnormality associated with the use of captopril during pregnancy.

A 30-year-old White woman had a history of severe hypertension during her previous pregnancies, and a diagnosis of renovascular hypertension had been made. She was being treated with captopril as well as propanolol and amiloride, having been found resistant to all other forms of antihypertensive therapy; the captopril, which had been released on a trial basis, produced excellent results when added to the regimen. She had decided against sterilization, in spite of having been warned about the dangers of falling pregnant while on therapy, and when she became pregnant termination was decided on because of her poor general prognosis and reports of fetal death in animal experiments.

A routine vaginal termination of pregnancy was performed and a small and obviously malformed fetus was found. Laparoscopic sterilization was carried out at the same time.

On macroscopic examination of the fetus the left leg was seen to end at the mid-thigh. No distal development was noted. The other limbs appeared normal. The trunk was normal, and so were the facial structures. Above the base of the skull, however, further abnormalities were seen and no obvious skull formation was noted above the brain tissue.

Although propanolol and amiloride are not recommended for use during pregnancy we are unable to find reports of fetal abnormality associated with their use. The distributors of captopril have described a fetal wastage of approximately 60% in pregnant rats, but no teratogenic effects have been noted. As far as we can ascertain this is probably the first described case of fetal abnormality associated with the use of this drug, and in fact probably the first pregnancy during which it has been used. Although an obvious cause-and-effect relationship cannot be documented at this stage — especially when we consider possible interactions of the other two drugs used — we feel that this case should be brought to readers’ attention and that patients should be warned about the possible dangers of the drug. Female patients on captopril should make certain that they do not become pregnant (as in fact is advised by the distributors) until further information becomes available.

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Etileenoksiedsterilisering — ’n waarskuing

Aan die Redakteur: Ons het met belangstelling die brief van Coetzee et al. gelees. In hierdie brief word verskyn enkele beelskynighede gemaak wat addisionele koste vir instandhouding van etileenoksiedsterilisering verhoog, behels. As basis vir hierdie beelskynighede is gemeen dat vier operateurs van eenhede wat daagliks gebruik word, deelsies, translokasies of disentriese chromosome (wat meer algemeen voorkom; en of dit inderdaad gekoppel kan word aan kontak met etileenoksied. Dit sal waardeer word indien die skrywers inhoud van hierdie ware afwykinge artefakte is en of dit inderdaad gekoppel kan word aan kontak met etileenoksied. Dit sal waardeer word indien die skrywers die bewyse wat vir die use van hierdie ware afwykinge artefakte is en of dit inderdaad gekoppel kan word aan kontak met etileenoksied. Dit sal waardeer word indien die skrywers inhoud van hierdie ware afwykinge artefakte is en of dit inderdaad gekoppel kan word aan kontak met etileenoksied.
A case of mixed connective tissue disease

To the Editor: A case of mixed connective tissue disease is reported because of its apparent rarity in this country and its important prognostic features.

A 22-year-old woman was seen on 13 August 1980. She complained of the following: (a) purple fingertips for years with no swelling of the hands; (b) arthralgia for 1 year with no joint swelling; and (c) muscle pain associated with weakness of and stiffness in the limbs. In December 1979 she had had a possible lung infection with bilateral pleural effusions, which had cleared rapidly on antibiotics. There had been no skin rash or photosensitivity, alopecia or dysphagia, elevation of temperature, mucous membrane lesions or neuropsychiatric symptoms.

Her general practitioner had tried various non-steroidal anti-inflammatory drugs, but on occasions she was so weak and in so much pain that only intramuscular steroids could get her out of bed.

On clinical examination the main features were acrocyanosis of the fingers and toes, cutis marmorata, tender metatarsophalangeal joints without swelling, and proximal muscle tenderness and weakness of the limbs. There were no other features of systemic lupus erythematosus (SLE) or scleroderma.

The results of laboratory investigations were as follows: haemoglobin concentration 120, white cell count 2.9 and later 3.1; ESR (Westergren) 60 mm/1st h; RA negative; C-reactive protein negative; lupus erythematosus (latex) negative; antinuclear factor positive (1/1280 homogeneous pattern, which is unusual); double-stranded DNA measured by radio-immunooassay negative; extractable nuclear antigen (ENA) 1/64 (ENA treated with ribonuclease became negative, therefore the titre of 1/64 represented ENA); urine — microscopically and chemically clear; urea, uric acid and creatinine levels normal; creatinine clearance normal; IgG 28,000 (raised); IgA 2,89; IgM 1,63; and IgE 600 x 10^3 (raised). Oesophageal motility studies were not done. These features were similar to those described by Sharp et al.

The patient responded dramatically and rapidly to prednisone and azathioprine and when last seen on 3 August 1981 was asymptomatic with a haemoglobin concentration of 142, an ESR of 12 mm/1st h and a white cell count of 5.2. The urine was clear. She was taking prednisone 7.5 mg on alternate days as maintenance treatment.

The condition is described as an overlap syndrome of SLE, 'scleroderma' and polymyositis. It is important to note that serious organ involvement as in SLE does not usually occur and that renal function is uniformly unaffected.

The demonstration of ENA seems to be of diagnostic importance. Whether the condition actually represents an entity in itself or is just a variant of SLE is still being debated.

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