Our patient developed psoriatic lesions at the age of 32, and after 8 years migrant arthralgias. At the age of 51 he developed necrotic papular lesions and asthenia. At the age of 32, and after 8 years migrant arthralgias. After 8 months a diagnosis of HCV infection was made, on the evidence of anti-HCV antibodies positivity. On admission to our department, physical examination revealed numerous erythematous papular nodular lesions and some ulcerocnecrotic lesions, livedo reticularis, a purplish motting of the skin, and multiple psoriatic lesions. Laboratory findings showed ESR 75 mm/hr, AST 169 IU/l, ALT 147 IU/l; the presence of antibody anti-HCV was positive, detected by RIBA test. HCV-RNA test was positive, showing an active viral replication. Latex-agglutination test for rheumatoid factor was strongly positive. Serum immunoelectrophoresis revealed type III cryoglobulinaemia.

Because of the worsening of psoriatic lesions with the use of interferon alpha and the contraindication to the use of immunosuppressors and prednisone due to the contraindication to the use of immunosuppressors and prednisone due to the presence of antibody anti-HCV, we chose to use iloprost. Iloprost is a stable prostacyclin analogue, not only demonstrated that prostacyclin or its stable analogue partially inhibits the adhesion of polymorphonuclear cells and lymphocytes to endothelial cells, and this has to be considered in the treatment of ischemic diseases whatever the aetiology is, since it is well-established that neutrophil adhesion to the endothelium plays a central role in ischemia-reperfusion injury (6). We therefore used i.v. iloprost 2 ng/kg/min, administered for 6 hours daily for 5 days. At the end of the treatment, a substantial improvement occurred (Fig. 1) with the disappearance of necrotizing lesions.

We conclude that the immune response to HCV and the cryoglobulins related to infection can lead to several clinical features, among which papular-nodular and ulcerocnecrotic must be considered. In this case, but also in other kinds of cutaneous involvement, iloprost may be a useful tool when other therapies are not available, or as an adjunct to steroids and immunosuppressors.

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Reprints will not be available from the author.

References

Letters to the Editor

A mistake in the history of aspirin

Sirs,

We would like to point out a widespread missapprehension in the rheumatological literature. In several histories of aspirin (1-4) two Italian chemists, Luigi Valentino Brugnatelli and Felice Fontana, are credited with the extraction of salicin from willow bark in 1826, two years earlier than Johann Andreas Buchner, Professor of Pharmacy in Munich, Germany (5). Brugnatelli and Fontana were eminent Italian chemists at the beginning of the 19th century. Brugnatelli was Professor of Chemistry at the University of Pavia and Fontana was the first Director of the Museum of Natural History in Florence, but neither of them conducted research on salicylic compounds. Furthermore, they both had passed away before 1826; Felice Fontana died in 1805 and Brugnatelli in 1818. The first extraction of the active component of willow bark was actually performed in 1824, i.e. two years before the reported date, by two other Italian researchers, both of whom were pharmacists – Bartolomeo Rigatelli in Verona, and Francesco Fontana in Lazise, near Verona. Rigatelli named the drug “salino amarissimo antifebrile” (bitter febrifugal saline), while Fontana utilized the same term – salicin – that a few years later was to be adopted by Buchner. Unlike Brugnatelli and Felice Fontana, they were not connected with academic world and they published the results of their studies in local journals (6, 7). This may explain the quippro quo, together with the assonance between Brugnatelli and Rigatelli and the homonymy between Felice and Francesco Fontana.

It was not easy to retrace the origin of the mistake. The earliest paper in the international literature in which we found a citation of Brugnatelli and Fontana was that by Julius Wohlgemuth in 1899 (8), but they had already been erroneously cited in 1845 by Raffaele Piria (9), another Italian chemist who in 1838 (10) was the first to isolate salicylic acid from salicin. Progress in any field is built of of many little stones that a few years later was to be adopted by Buchner. Unlike Brugnatelli and Felice Fontana, they were not connected with academic world and they published the results of their studies in local journals (6, 7). This may explain the quippro quo, together with the assonance between Brugnatelli and Rigatelli and the homonymy between Felice and Francesco Fontana.

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BCG as a new therapeutic and prophylactic agent in patients with severe oral aphthosis

Sirs,

Recurrent aphthous ulcers (RAU) is a major public health problem that has been considered as the most frequent oral mucosal disease in children and adults, affecting 20-25% of the world population (1). Its etiopathogenesis is obscure although immunological derangement has been proposed by several investigators (2-4). The therapy of this medical problem remains an important dilemma. Many therapeutic trials that have shown benefit in the relief of oral aphthosis of antibiotics, anti-inflammatory, immunomodulators, anesthetic and alternative (herbal) remedies (4) has been proposed by several investigators (2-4).

BCG was introduced as a vaccine against tuberculosis (TB), but in recent years it has also been found to act as an immunomodulator in cases of leprosy, as the incidence of this disease was reduced tremendously after introduction of the BCG vaccine (7). BCG has been used successfully in the treatment of alopecia areata (6), malignant melanoma (6), viral warts (7), and diffuse cutaneous leishmaniasis (6) etc. The present work showed that BCG is effective in controlling aphthosis. This has been shown clearly during the second month and improvement continued even during the 3-month follow-up. This supports the idea that BCG has a therapeutic and prophylactic role in the management of oral aphthosis. Further follow-up is needed for further evaluation of this therapy.

The mechanism of the action of BCG in the treatment of oral aphthosis cannot be clearly explained but most probably it is through its immunomodulatory effect. This BCG immunotherapy also has been tried in Behcet’s disease and the preliminary result is encouraging (Sharque and Hayami, 2004; unpublished data). In conclusion, the BCG vaccine is an effective new mode of therapy in patients with oral aphthosis and further evaluation through double-blinded studies is indicated to overcome the bias effect of spontaneous remission.

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