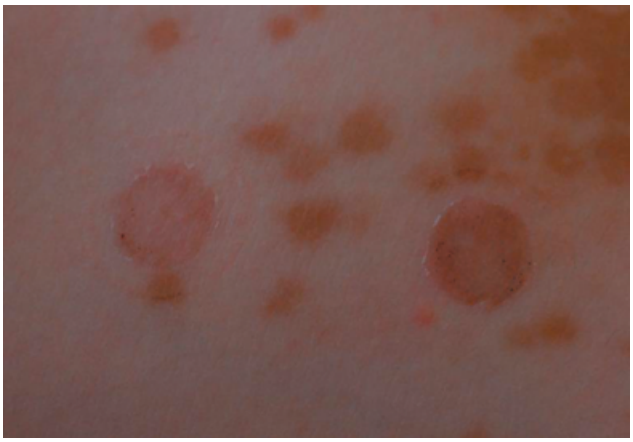

Figure 1 Two suction blister epidermal grafts 15 days after placing them onto the suction blister vitiligo sites.

blister donor wound.[2,3] Interestingly, the grafted epidermis was attached permanently onto the suction blister sites of all patients, similar to a split thickness skin graft.

Here, we treated segmental vitiligo, in a 19-year-old woman, with suction blister epidermal grafting. We used suction blisters at both the donor and recipient sites and observed the course of the grafted epidermis in the recipient areas. As expected from the results of previous studies,[2,3] epidermal grafts were attached and were permanent at the suction blister recipient sites (Fig. 1). Based on our experience, when we used the CO_2 laser for recipient site preparation, the epidermal grafts were usually detached in about one week.

Previously, suction blisters were used for recipient site preparation of an epidermal graft, and it was suggested that epidermal grafting may be an effective treatment not only for stable vitiligo but also for progressive vitiligo.[4] However, the fate of the grafted epidermis was not mentioned.

We found that the epidermal grafts could be attached permanently onto the suction blister vitiligo sites. This observation suggests that the use of suction blisters for recipient site in epidermal grafting for vitiligo might be better than the other currently available methods. However, it is not always possible to produce suction blisters on the skin over curved surfaces, eyelids and lips, and on the skin covering loose connective tissue. In addition, the size of the blisters induced by the suction is limited. To improve the outcome of epidermal grafting for vitiligo, further studies comparing suction blisters with other methods for recipient site preparation are necessary.

D-Y Lee,* J-H Park, H-Y Park, J-H Lee
Department of Dermatology, Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Korea
*Correspondence: D-Y Lee. E-mail: dylee@skku.edu

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Umbilical sore

Editor

The 'dynias' are a group of chronic, focal pain syndromes with a predilection for the orocervical and urogenital regions. They include glossodynia, carotidynia, vulvodynia, orchidynia, prostatodynia, coccygodynia, and proctodynia.[1] The controversy that surrounds this group of disorders, which ranges from questioning their existence to suggesting that they are purely psychosomatic, is counterbalanced by an extensive literature attesting to their organicity.

Vulvodynia and soremouth describe chronic burning and/or pain in the vulva or mouth without objective physical findings.[2,3] From our point of view, sore mouth and vulvodynia frequently constitute a clinical sign of depression.

A 48-year-old lady presented with burning umbilical sensation. The patient had been treated with topical steroids, topical antifungal and several combinations of topical creams with no effect.

Clinical observation revealed a normally coloured skin and no inflammatory changes.

The psychological questionnaire showed marked tiredness upon waking up in the morning. She also referred to sleep disturbances (i.e., tertiary insomnia). The patient's mother has been deceased 6 months prior to consultation.

The patient received fluoxetine 20 mg daily in a single morning dose. She was told not to use any cream on that area. Twenty days later, the patient was absolutely free of symptoms.

The variety of manifestations of a psychodermatosis gives difficulties to the non-trained dermatologists to get the right diagnosis.[4] Young dermatologists should be trained to suspect and properly perform a psychological questionnaire to any patient attending for a disturbance on the mouth or genital area.

The training on the use pf psycho drugs should also be contemplated on most training programs.

The degree of discomfort that these patients have due to these extremely unpleasant burning sensations affecting either the mouth, the genitalia, the anal area or the umbilicus should alert 'the third ear' of the dermatologist in order to properly diagnose and treat these patients.[5]

The key point on the therapy is that the patients seeking for a dermatologist but consulting for a psychological disturbance will

never accept to be seen by a psychiatrist. In large institutions, the possibility of working in a 'liaison clinic' will help most difficult-to-treat patients.[6]

The dermatologist who deals properly with this type of patients usually gets great amounts of positive feedback from them. The therapy not only will give great relief on the symptoms but will also improve drastically the quality of life of that patient.

From the review of the literature, this is the first report of umbilical sore, and from our point of view, it should be included into the alarm signs when looking for a psycho-dermatological disease in a patient consulting the dermatologist.

R Grimalt,* F Grimalt
Department of Dermatology, Hospital Clinic, University of Barcelona, Barcelona, Spain
*Correspondence: R Grimalt. E-mail: grimalt@ub.edu

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Comment on the letter by Sadighha and Zahed on hair darkening after treatment with cyclosporin in a patient with psoriasis

Editor

In their letter, Sadighha and Zahed report a male psoriatic patient who developed hair darkening after treatment with cyclosporin.[1] Interestingly, a 38-year-old female psoriatic patient developed skin darkening on two occasions, 1 year apart, each after short-term course of cyclosporin. The patient has a long history of severe extensive plaque psoriasis that was not responding well to conventional therapy over the years. In each of the two short courses, cyclosporin was administered orally at the dose of 5 mg/kg daily in two divided doses and psoriasis cleared in about three months and cyclosporin administration was then stopped. Such intermittent short courses of cyclosporin therapy have been advocated to minimize renal impairment.[2] Skin darkening particularly of the face developed about 1 month after the start of cyclosporin therapy. Skin returned to normal colour gradually over several months following the end of treatment. Although it has been demonstrated that cyclosporin actually inhibits melanogenesis *in vitro*, it was clearly stated that these findings are inconsistent with the suggestions that systemic cyclosporin causes skin hyperpigmentation.[3] Skin darkening with particular affection of the flexural creases related to cyclosporin has been reported in a patient with renal transplant during 3 months cyclosporin therapy that resolved after cyclosporin was discontinued.[4] Intense hyperpigmentation of the face and elsewhere possibly attributed to cyclosporin has been described before in a patient with acute myeloid leukaemia who received cytarabine, daunorubicin and cyclosporin.[5]

A Gohar*†‡
†Independent Dermato-Venereologist, Private Medical Sector, Egypt.
‡Gohar's Skin and Sexual Health Clinic, Doctors' Tower, Central Corridor, 6 October City, Egypt
*Correspondence: A Gohar.
E-mail: amrgohar@hotmail.com

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