is associated with an increased frequency of HLA alleles DRB1*04 and DQB1*0302 as compared with a control population. Autoimmune CSU results from synthesis of IgG antibodies against IgE and/or FcεRIα on mast cells and basophils and is assessed by ASST, basophil histamine release assay, and immunoassays. All our patients were ASST positive, and half of them had a family history of AIT, vitiligo, and/or other autoimmune disorders such as rheumatoid arthritis. In another study, the prevalence of CSU was significantly elevated in generalized vitiligo probands and their first-degree relatives.

In summary, we found that vitiligo preceded CSU development in all cases and may be viewed as a prognostic factor for APS-IIIC in CSU patients. While in previous reports CSU as a component of APS-IIIC was successfully treated with PUVA and azathioprine, we observed rapid response to CsA and subsequent induction of remission in 3 patients in whom antihistamines proved ineffective. The obvious limitation of our study is the fact that we did not perform HLA genotyping and tests for IgG autoantibodies to IgE and/or FcεRIα in our patients. That may be a potential area for future research.

**References**


**Dapsone and sulfasalazine combination therapy in dermatitis herpetiformis**

Editor,

Dermatitis herpetiformis (DH), a cutaneous manifestation of a gluten-sensitive enteropathy, usually presents as intensely pruritic inflammatory eruptions on the knees, elbows, scalp, and buttocks. This chronic condition is often well controlled by a gluten-free diet and dapsone. However, in patients unable to fully tolerate dapsone, treatment options are often limited, such as sulfapyridine, which is no longer commercially available in...
the United States. Sulfasalazine, used more commonly in the
treatment of other autoimmune diseases, offers an alternative.
We present two patients who obtained partial control with dap-
sone but were unable to tolerate increases in dosage. Both
patients had a complete response with the addition of low
dosage sulfasalazine.

The first patient, a 59-year-old female with a history of breast
cancer, hypertension, and Raynaud’s disease, presented with
pruritic vesicular lesions on her elbows and knees bilaterally.
A skin biopsy confirmed the diagnosis of DH. An evaluation for
celiac disease was negative. Initial treatment included a gluten-
free diet and dapsone 100 mg/d. Over a 2-year period, the
patient observed new lesions along with a few episodes of pruri-
tus each month. The dapsone dosage was not increased
because of anemia. Instead, sulfasalazine 500 mg/d was
added. She reported complete control of her disease with this
combination treatment at her 6-month follow-up.

Our second patient, a 58-year-old female with asthma, bron-
chitis, and celiac disease, presented with pruritus and excoria-
tions despite following a gluten-free diet. Histopathological
studies confirmed the diagnosis of DH. The patient was initially
treated with dapsone 75 mg/d requiring an increase to 100 mg/
d after periodic cutaneous lesions and pruritus. At her follow-up
visit, she felt she developed symptoms consistent with a sen-
sory neuropathy after the dapsone dosage was increased. The
dapsone dosage was decreased to 75 mg/d, and sulfasalazine
was added at 500 mg/d, which reestablished complete control
of her DH. A neurology evaluation concluded the neuropathy
was secondary to her poorly controlled diabetes mellitus. She
remained stable after 6 months of follow-up.

Tissue transglutaminase (ttg) autoantibodies have been
reported as a sensitive marker in DH and can be measured
using a commercially available ELISA (<19 negative). A decline
in the anti-ttg antibody titers was observed post-treatment with
sulfasalazine in both patients. Case 1 decreased from 30 to
undetectable (<19) and Case 2, 75 to 72.

Dapsone with a gluten-free diet usually results in rapid clinical
improvement in DH. Dapsone, like any systemic medication, can
have intolerance. Alternative monotherapeutic agents in DH
have included a tetracycline group of antibiotics with
niacinamide and sulfapyridine. However, patients can encounter
issues with these therapies including lack of comparable effi-
cacy, decreased accessibility, and increased cost.

Sulfasalazine has been reported as successful monotherapy
in patients who initially failed or were unable to tolerate dapsone
(Table 1).8,4 Sulfasalazine metabolism results in the formation
of two metabolites, 5-aminosalicylic acid (5-ASA), and sulfapyri-
dine. Sulfapyridine blocks the recruitment of neutrophils by
inhibiting formation of leukotriene B4.5 5-ASA exerts a local
anti-inflammatory effect on the bowel mucosa, possibly providing
a dual antiinflammatory effect on both cutaneous and gas-
trointestinal mucosae. However, since dapsone use is more
common in DH, sulfasalazine as monotherapy may not have the
same clinical efficacy.

The addition of a second drug can be useful in treating
autoimmune diseases when increasing the dosage of the pri-
mary agent is not possible. Combination therapy has not been
reported in the treatment of DH. Our experience suggests lower
dosages of sulfasalazine can be effective and well-tolerated
when combined with dapsone. This combination would provide
a much needed alternative treatment strategy for DH. Further
long-term studies are needed to validate this combination for
efficacy and tolerability.

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2014; 348: g2557.
2 Goldstein BG, Graham Smith J Jr. Sulfasalazine in dermatitis

Table 1 Sulfasalazine as monotherapy in dermatitis herpetiformis patients (review of the literature)

<table>
<thead>
<tr>
<th>Patient age (years)/Gender</th>
<th>Initial treatment</th>
<th>Dose of initial treatment</th>
<th>Dose of Sulfasalazine</th>
<th>Length of time to response from Sulfasalazine</th>
<th>Side effects from Sulfasalazine</th>
</tr>
</thead>
<tbody>
<tr>
<td>55/F</td>
<td>Dapsone</td>
<td>200 mg/d</td>
<td>2 g/d</td>
<td>1 week</td>
<td>N/A</td>
</tr>
<tr>
<td>79/M</td>
<td>Dapsone</td>
<td>100 mg/d</td>
<td>2 g/d</td>
<td>2 weeks</td>
<td>N/A</td>
</tr>
<tr>
<td>42/F</td>
<td>Dapsone</td>
<td>100 mg/d</td>
<td>2 g/d</td>
<td>2 weeks</td>
<td>N/A</td>
</tr>
<tr>
<td>14/M</td>
<td>Prednisone, sulfoxone sodium, and sulfapyridine</td>
<td>Unknown</td>
<td>2 g/d</td>
<td>1 week</td>
<td>N/A</td>
</tr>
<tr>
<td>18/M</td>
<td>Prednisone</td>
<td>Unknown</td>
<td>3 g/d</td>
<td>1 week</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Firmly fixed dressing with tie-over: a useful technique to reduce postoperative hematoma formation for surgical wound of the scalp

Editor,

Dressing the scalp is difficult because there is no skin for adherence. Moreover, compression of the surgical wound is difficult, which can lead to postoperative hematoma. Several reports on dressing of the scalp exist,\textsuperscript{1–4} however, reports on good compression and less gap between the gauze and scalp are lacking.

We developed a new method for firmly fixing the dressing, using the tie-over technique for surgical wounds of the scalp, compared it with the conventional dressing method (gauze and elastic net), and investigated its efficacy.

Between April 2011 and March 2016, we performed tumorectomy for skin tumors and subcutaneous tumors on the scalp in 138 cases (80 male, 58 female; mean age 44.5 years, range 2–88 years). After tumor resection and closure, we made symmetric fixed sutures approximately every 2 cm, using 3-0 or 4-0 nylon, approximately 2 cm from the surgical wound in cases of skin tumors or near the dead-space edge in cases of subcutaneous tumors (Fig. 1a,b). A gauze pad was piled over the sutures (Fig. 1c). Then, the fixed sutures were tied over the gauze pad with moderate pressure (Fig. 1d). Postoperative images for dressing with the conventional and tie-over methods are shown in Figure 1e,f. We inserted a drain for patients who had received stronger anticoagulant medication (e.g., clopidogrel) or had uncontrolled hypertension or dead space >10 cm\textsuperscript{2}. On postoperative days 1 or 2, the tied-over knots were cut and gauze pad was removed; the drain, if placed, was also removed. The surgical wound could thereafter be washed without a gauze, and sutures were removed based on adaptation of the wound and patients’ choice.

The average diameter of the wounds was 3.3 cm (range 1.7–7.5 cm). We compared the dressing with the tie-over method [tie(+) group] and conventional method [tie(−) group] for incidence of postoperative hematoma and wound dehiscence in all cases, including short wounds (<3.5 cm), long wounds (≥3.5 cm), and skin tumor and subcutaneous tumor cases (Table 1). Data were analyzed using the Statistical Package for

![Figure 1](https://example.com/figure1.png)

(a) Subcutaneous tumor of the scalp. (b) After resection of subcutaneous tumor and wound closure, symmetric fixed sutures with tie-over are made. (c) A gauze pad is piled over the wound. (d) The fixed sutures are tied over the gauze pad with moderate pressure. (e) Postoperative image of the conventional dressing method (gauze and elastic net). (f) The postoperative picture of the tie-over dressing (new) method

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