

Orf contamination may occur during religious events

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To the Editor: We read with interest the case report entitled "Facial Orf" by M. G. Bodnar, O. F. Miller, and W. B. Tyler in the May 1999 issue of the Journal (1999;40:815-7). The authors consider orf to be an occupational disease. However, our experience is quite different; religious habits may also be a source of contamination. In the literature, only one article in 1982 mentioned a similar event, describing an orf epidemic occurring in Izmir, Turkey after a ritual feast.¹

Our department of dermatology is located in the center of Brussels, a city of 1 million inhabitants, capital of Belgium and the European Union. Next to our hospital lives a large immigrant population; most of them are Moroccan or Turkish. All our orf cases observed in 1999 (23 patients) occurred during a 15-day period. All patients, except one, were Muslim.

We observe such an outbreak of orf every year, which occurs 2 or 3 weeks after 'Aid el Kebir' ('Aid el Adha,' the Feast of Sacrifice). This Islamic feast celebrates the sacrifice of Ibrahim (Abraham); Yahve replaces Ismael with a lamb, thereby abolishing the human sacrifice. The exact day of 'Aid el Kebir' varies; it is related to Ramadan and is celebrated 2 months and 10 days after its end. During this feast, each Muslim family kills a sheep. The technique of the sacrifice is a ritual; the sheep has to be bled alive, which implies close and violent contact with the angry animal, held with bare hands. Therefore viral contamination occurs easily.

Only men may kill the sheep; however, we have noted a similar number of women contaminated by orf. All the women had manipulated the skin and meat of the animal, which appears to be sufficient exposure to become infected. Only one of our patients was not Muslim, but had helped his neighbors during the festival.

Therefore orf is not restricted to a rural population, shepherds, and butchers; contamination may occur when religious customs are observed (eg, 'Aid el Kebir'). Each year, we can estimate the date when the first cases may occur, according to the Islamic calendar. In 2000, it will start at the beginning of April.

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REFERENCE

1. Gunes AT, Gezen C, Kapdaghi H, Marschall HJ. Ecthyma contagiosum epidemics in Turkey. *Hautarzt* 1982;33:384-7.

Finasteride and the hair cycle

To the Editor: The article by Leyden and associates "Finasteride in the Treatment of Men with Frontal Male Pattern Hair Loss" (J Am Acad Dermatol 1999; 40:930-7) shows that the hair count increases during the first months of treatment and remains stable after the first year; clinical improvement continues to increase over time. We give further evidence of a double effect of finasteride on hair growth.

The increase in the hair count observed during the first year of treatment indicates that the drug actively promotes the re-entry of resting follicles into the anagen phase, including those follicles that have abnormally prolonged their telogen phase. These follicles are empty because they have shed the telogen shaft before starting the production of a new hair shaft, as occurs in normal follicles. The phenomenon of the "empty follicles" strongly contributes to the hair thinning that clinically characterizes androgenetic alopecia.^{1,2} Differences in the increase of the hair count between different patients and different scalp areas³ may partially be related to the magnitude of the empty follicle phenomenon at baseline. The anagen-promoting effect of finasteride (increase in the hair count) is evident during the first year of treatment and is responsible for the "early improvement" noticed as early as the third month of treatment in some patients.

The continuous improvement of the subjective assessments (patient self-assessment, investigator assessment, global photography assessment) after the first year of treatment is not related to the hair count that remains stable but to the action of finasteride on anagen growth. The prolongation of anagen induced by the drug results in progressive thickening and elongation of miniaturized and intermediate hair. This effect explains why patients continue to experience improvement of the appearance of the hair even if the hair count remains stable.

Therefore hair count and subjective assessments document two different phenomena (Table I), which may be independent, and we should keep in mind

Table I. Effects of finasteride

Early (3-6 mo)	
Induction of anagen	→ Increased hair count
	Decreased anagen shedding
Late (after 1 y)	
Prolongation of anagen	→ Hair thickening and elongation
	→ Improvement in the hair quality

that patients may clinically improve even if their hair count does not considerably increase.

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REFERENCES

1. Courtois M, Loussauarn G, Hourseau C, Grollier JF. Ageing and hair cycles. *Br J Dermatol* 1995;132:86-93.
2. Guarrera M, Rebora A. Anagen hairs may fail to replace telogen hairs in early androgenetic female alopecia. *Dermatology* 1996;192:28-31.
3. Kaufman KD, Olsen EA, Whiting D, Savin R, De Villez R, Bergfeld W, et al. Finasteride in the treatment of men with androgenetic alopecia. *J Am Acad Dermatol* 1998;39:578-89.

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Calciphylaxis and antiphospholipid antibody syndrome

To the Editor: We read with interest the clinical review by Oh, Eulau, and Tokugawa regarding calciphylaxis in the June 1999 issue of the Journal (*J Am Acad Dermatol* 1999;40:979-87). Calciphylaxis is a rare condition seen in patients with chronic renal failure and hyperparathyroidism.¹ A clinical simulator of calciphylaxis is antiphospholipid syndrome (APS), a syndrome of arterial and venous thrombosis associated with autoimmune disease.²

We report a case of coexistent calciphylaxis and antiphospholipid syndrome, the first such case to our knowledge. A 40-year-old white woman with systemic lupus erythematosus (SLE), APS, and chronic renal failure secondary to SLE presented with a 4-day history of painful fingers that had begun 4 days after warfarin, given for placement of dialysis catheter, had been stopped. She had not yet begun to receive dialysis. She had been diagnosed with APS 2 years earlier when she had a cerebrovascular accident and was found to have IgG anticardiolipin antibody. She had been receiving long-term anticoagulant therapy, as well as azathioprine (100 mg daily) and prednisone (5 mg daily), for her SLE and APS. Her fingers became gangrenous over the next 10 days, and indurated, reticulated purpura developed on her legs. The diagnosis of calciphylaxis coexisting with an acute exacerbation of APS was made by histopathologic findings of calcified small vessels with fibrin thrombi within; elevated serum parathyroid hormone, 2069 pmol/L (normal range, 12-72 pmol/L); elevated serum phos-

phorus, 22.7 mg/dL (normal range, 2.5-4.9 mg/dL); and with normal corrected serum calcium. The patient had been noncompliant in taking calcium carbonate supplements for chronically elevated phosphorus levels.

The patient underwent parathyroidectomy; 2 days postoperatively, anti-tumor necrosis factor alpha and plasmapheresis were initiated. Five days postoperatively, the skin lesions were subsiding, with lessening in the tenseness and the size of the areas of reticulated violaceous erythema on her legs, arms, and hands. Ulcers with granulation tissue persisted in pressure areas of the buttocks and the backs of her legs; they were treated with topical muciprocin and zinc oxide. The patient received 10 cycles of plasmapheresis. She was also started on a regimen cyclophosphamide (25 mg every 48 hours), and azathioprine was stopped. One month after admission, hand surgeons debrided and amputated multiple fingers, and the patient was discharged home. She continues to receive dialysis, low-molecular-weight heparin, cyclophosphamide, and prednisone, as well as hyperbaric oxygen. Despite these measures, she has undergone disarticulation at the left wrist because of further development of gangrene.

In this patient, it appears that the combined treatment of calciphylaxis and APS led a moderate abatement of cutaneous lesions. Her case illustrates the possible interplay of these two disease conditions and may help to shed light on their pathophysiology.

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REFERENCES

1. Angelis M, Wong LL, Myers SA, Wong LM. Calciphylaxis in patients on hemodialysis: a prevalence study. *Surgery* 1997;122:1083-90.
2. Greaves M. Antiphospholipid antibodies and thrombosis. *Lancet* 1999;353:1348-53.

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Treatment of spider veins with the 595 nm pulsed-dye laser

To the Editor: We read with interest the study by Bernstein et al entitled "Treatment of Spider Veins with the 595 nm Pulsed-Dye Laser" (*J Am Acad Dermatol* 1998;39:746-50). In this study, the authors