THE EDITOR.

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HYPERPIGMENTED MACULES OCCURRING DURING SULPHONE THERAPY

Dear Sir,

May I crave the courtesy of your columns in order to answer the letter from Dr. Basil Nicholson appearing in *Leprosy Review* (1959), **30,** 254?

Since I was well aware that certain drugs (including phenolphthalein) commonly recognized to be concerned in precipitating "fixed eruptions", might, in deeply pigmented skins, cause a hypermelanotic rash, I was naturally at especial pains to exclude such possibilities before concluding that the phenomena encountered were to be attributed to sulphones.

Dr. Nicholson's perfectly reasonable objection can be shortly answered: In the Yakusu medical area (Oriental Province, Belgian Congo), the macules appeared only in patients undergoing sulphone therapy (except two who had received sulphaguanidine and sulphathiazole respectively) (Browne, 1959—2); the condition was not seen in any other person in that district.

The population concerned (about 45,000 persons) was medically inspected annually by me and teams of competent trained medical assistants (*Infirmiers diplômés*); a highly organized and adequately controlled rural health service comprising 18 dispensaries and 35 treatment centres, brought medical facilities within the reach of all; proprietary medicines were not on sale in the markets, openly or clandestinely, and self-medication was virtually non-existent; any case of hypermelanosis occurring between the annual medical inspections was at once the subject of a detailed report to me by the *Infirmier* and subsequently examined by me; some of the patients with hypermelanotic macules had admittedly received other drugs than sulphones at the dispensaries, in known and recorded doses,

but no product could be incriminated as a causative or potentiating factor in the production of the rash—in particular, no phenol-phthalein had been given in any form to any person at any dispensary or treatment centre throughout the district.

The clinical features of the condition (Browne, 1959—1), indicate that sulphones are responsible, but that the mechanism may not be uniform: thus, some cases conform to the well-known fixed drug eruption pattern, with focal exacerbation on every administration of the incriminated product, while others do not.

Working now in Nigeria, however, I am better able to appreciate Dr. Nicholson's reluctance to attribute to sulphones the cases of blue-black macules that he and Dr. Healy have studied. In addition to 3% of patients under controlled institutional sulphone therapy at Uzuakoli who develop either discrete or diffuse hypermelanosis, preceded or not by classical "sulphone dermatitis" local or general, I am at present investigating essentially similar conditions in non-sulphone cases, due to a variety of drugs, including phenol-phthalein, mepacrine and acetyl-arsan; to extracts of leaves and nuts grown hereabouts; to local applications of concentrated antiseptics and of aqueous infusions of leaves; to contact dermatitis and light sensitization followed by topical whealing, vesiculation and hypermelanotic macules.

Thus, some of the Ossiomo cases of characteristic appearance but of non-specific aetiology, may well have been caused by factors other than sulphones—including preparations containing phenol-phthalein (purgatives, intestinal lubricants, tooth pastes, mouth washes, ice cream, are among the 104 products mentioned by Belote and Whitney (1937).) I should be most interested to investigate these cases at the earliest opportunity, and to ascertain the incidence in that series, of hypermelanotic macules attributable to sulphones.

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