symptoms. Haematological values, plasma calcium, electrolyte, and urea concentrations were all normal before intubation. Bacteriological and virological studies of secretions from the nose and nasopharynx gave negative results.

Extubation was attempted after two days, but she had to be reintubated one hour later because of persistent severe stridor. She was extubated again on day five. Direct laryngoscopy showed hyperaemia and ulceration of the vocal cords, which moved normally. The subglottic area was normal. She could not maintain an unobstructed airway and was intubated for a third time.

At 10 days the vocal cords were inflamed and ulcerated. The buccal mucosa had healed but her chest wall was still strikingly erythematous. Tracheostomy was performed as she remained stridulous after further extubation. The tracheostomy tube was removed seven days later, by which time her vocal cords looked normal. Thereafter she made a full and uneventful recovery.

Comment

Dettol is a widely used household disinfectant, described on the label as non-poisonous. Serious poisoning is rare, though deaths have been reported in adults.[1 2] In one study of 687 cases of Dettol ingestion[2] there were three deaths. The toxic effects of Dettol and its active constituents are well documented,[1 3] and its respiratory complications include wheeze and respiratory depression. Stridor has not been reported, though in one patient tracheal corrosion was found at necropsy.[1]

Ulceration of the vocal cords in our patient was probably due to Dettol, perhaps following the induction of vomiting. Gastric emptying is generally advised as part of the management for potentially serious Dettol ingestion. If gastric lavage is carried out, or vomiting occurs or is induced, it would be a wise precaution to have facilities and staff available for tracheal intubation or tracheostomy.

I thank Dr Hamish Simpson for granting me permission to report this case.

[1] Meek, D, *et al*, *Postgraduate Medical Journal*, 1977, **53**, 229.
[2] Mant, A K, personal communication, 1979.
[3] Wade, A, and Reynolds, J (editors), *Martindale: The Extra Pharmacopoeia*, 27th edn, p 513. London, Pharmaceutical Press, 1977.

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Contact allergy to methoxsalen

Photochemotherapy (PUVA) is effective in treating psoriasis. Since a major report[1] in 1974 it has been extensively used. Earlier, furcoumarins (psoralens) had been advocated to repigment vitiligo.[2] In treatment with PUVA psoralen preparations are given either by mouth or topically as a solution, ointment,[3] or emulsion and are then exposed to long-wave ultraviolet light (UVA; 320-400 nm). For localised forms of psoriasis, particularly psoriasis of the palms and soles, topical application of psoralen is preferable. Although topical preparations have been used for some time, contact allergy to psoralen has not been reported. I here report two cases of allergic contact sensitivity to methoxsalen (8-methoxypsoralen).

Case reports

Case 1—A 50-year-old housewife who had had psoriasis for about 18 months, mainly on her palms, was treated with PUVA as her response to conventional local treatment was poor. Methoxsalen (0·15% Meladinine emulsion; Basotherm) was applied, and 30 minutes later the areas were exposed to a UVA light source. The procedure was repeated thrice weekly. Initially a slight improvement occurred, but after 16 treatments she developed an erythematous rash on her chin and complained of increased palmar irritation. This rash was thought to be a contact eczema due to Meladinine emulsion. Patch tests with the International Contact Dermatology Research Group (ICDRG) series were negative, but an allergic-type reaction occurred to 0·15% Meladinine emulsion. Subsequently she was patch tested with different constituents of the Meladinine emulsion. The table shows the results.

Results of patch testing two patients with ICDRG series and constituents of Meladinine emulsion at 48 and 96 hours

Substance tested	Form of substance	Case 1		Case 2	
		48 h	96 h	48 h	96 h
ICDRG series		–	–	–	–
Propylene glycol	10% aq sol	–	–	–	–
Benzalkonium chloride	1:1000 aq sol	–	–	–	–
Lanette (emulsifying wax)	as is	–	–	–	–
Spermaceti	as is	–	–	–	–
Span 40 (sorbitan derivative)	5% aq sol	–	–	–	–
Tween 40 (sorbitan derivative)	5% aq sol	–	–	–	–
Cetiol V (Basotherm)	as is	–	–	–	–
"	10% in petroleum	–	–	–	–
Meladinine emulsion	as is	++	++	++	++
Methoxsalen	10% in petroleum	++	++	++	++
"	1% in petroleum	++	++	++	++

ICDRG = International Contact Dermatology Research Group.

Case 2—A 56-year-old shop assistant with psoriasis of the palms of five months' duration had been treated with PUVA, as in case 1. There was steady improvement in the first six weeks. She then started to complain of increased irritation of her palms and spreading of rash to the fingers. Examination at that stage showed psoriasis of the palms and pompholyx eczematous changes of the fingers. She was patch tested with the ICDRG series and with 0·15% Meladinine emulsion and its constituents. The table shows the results.

Comment

By using psoralen topically the systemic absorption is reduced as well as the total exposure to UVA. As the topical preparations contain different ingredients allergic reaction to these substances may occur. Although psoralen preparations such as trioxsalen[4] and methoxsalen[3] have been used before, contact allergy to them has not been reported. Both our patients showed a contact allergy to methoxsalen.

The possible development of an allergic reaction to psoralen may be an important consideration in patients receiving PUVA treatment with topical psoralen preparations. Additionally, such patients may also be sensitised to oral psoralen, since ingestion of a contact allergen by a sensitised person can cause dermatitis.[5] Thus in patients whose response to topical PUVA is poor or in whom the psoriasis suddenly worsens during treatment with PUVA allergic sensitisation to topical psoralen should be considered.

I thank Drs J S Pegum and H Baker for their advice and permission to report their cases.
The individual constituents of Meladinine emulsion were kindly supplied by Drs Renovanz and Schulz (Basotherm).

[1] Parrish, J A, *et al*, *New England Journal of Medicine*, 1974, **291**, 1207.
[2] Lerner, A B, *et al*, *Journal of Investigative Dermatology*, 1953, **20**, 299.
[3] Petrozzi, J W, *et al*, *Archives of Dermatology*, 1977, **113**, 292.
[4] Walter, J E, *et al*, *Archives of Dermatology*, 1973, **107**, 861.
[5] Cronin, E, *British Journal of Dermatology*, 1972, **86**, 104.

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Corrections

Blood-pressure screening and supervision in general practice

The above paper by Professor J H Barber and others was printed in the *BMJ* of 31 March (p 843). We regret that the name of Dr G A Walker was inadvertently omitted from the draft list of authors we received. His address and name should have appeared in the list as follows: Bridge of Allan, Stirlingshire, G A WALKER, MB, MRCPGLAS, general practitioner.

Oral metronidazole in Clostridium difficile colitis

In the above paper by Dr N L Pashby and his colleagues (16 June, p 1605) the dosage of oral clindamycin was given wrongly in both case reports. It should have read 150 mg six-hourly (not 250 mg).