who are also "clotters" who develop deep vein thrombosis, and this may explain the lower incidence of deep vein thrombosis in the smokers as a whole.

None of these theories is really satisfactory but whatever the true explanation the observations are important when it comes to making decisions about which patients should be given anticoagulant therapy to prevent thromboembolic complications after myocardial infarction. Non-smokers join those with clinically significant varicose veins and those with a history of previous thromboembolism in the high-risk

group, in whom prophylactic anticoagulant therapy is indicated (Emerson, 1974; Emerson *et al.*, 1974).

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MEDICAL MEMORANDA

Lichenoid Eruption due to Methyldopa

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Many drugs can produce an eruption that may be histologically and clinically indistinguishable from or closely similar to lichen planus. Lichenoid eruptions occurring in patients receiving methyldopa appear to be rare. The following case illustrates a causal relation between the drug and the eruption. The diagnostic importance of establishing this relationship is emphasized.

Case Report

A 60-year-old housewife was found to be hypertensive in June 1971. Methyldopa 250 mg three times daily was begun and she became normotensive. In September 1972 she noticed a symmetrical rash on the forearms which spread to the trunk and legs. Itching was not severe. Treatment was continued.

When seen in June 1973 she had a symmetrical lichenoid eruption on the legs, trunk, and arms. The mucous membranes, scalp, and nails were spared. Biopsy showed hyperkeratosis, hypergranulosis, irregular acanthosis with flattening of the rete ridges, and a predominantly eosinophilic infiltrate in the upper dermis (see fig.). Methyldopa was stopped and her blood pressure was controlled with oxprenolol 80 mg twice daily. Fourteen days later the eruption was beginning to fade and by September it had cleared. In October methyldopa was restarted at a dose of 250 mg twice

daily. Seventeen days later a lichenoid eruption developed on the back and shoulders. Biopsy showed changes of lichen planus. Methyldopa was replaced by oxprenolol and seven days later the eruption disappeared.

Comment

Methyldopa is the alpha-methylated derivative of dihydroxyphenylalanine. Skin reactions in patients receiving methyldopa are not common. Dollery (1965) described three patients who developed a pruritic papular eruption on the legs, and Peterkin and Khan (1969) described four patients with a keratotic eczema on the palms and soles. Church (1973) reported on 13 patients with a seborrhoeic, dermatitis-like eruption which developed while taking methyldopa. There have been other instances of eruptions attributable to methyldopa (Almeyda and Levantine, 1973).

Stevenson (1971) reported the development of a lichenoid eruption in three patients on methyldopa after 18 months, five months, and six months of treatment respectively. The eruption subsided after discontinuing treatment but no provocation tests were performed on any of his patients. In our patient the lichenoid eruption first developed 15 months after starting methyldopa and reappeared only 17 days after re-starting the drug. The histological picture showed an eosinophilic perivascular infiltrate. These features suggest a causal relation between the drug and the eruption.

The clinical appearance of a lichenoid drug eruption may be indistinguishable from that of lichen planus. Occasionally there are atypical features such as pronounced scaling, eczematization and intense residual pigmentation (Samman, 1972). The histological picture is generally identical with that of lichen planus, though Winer and Leeb (1954) believe that there are differences in lichenoid drug eruptions, having observed in particular the presence of a prominent eosinophilic perivascular infiltrate in the dermis, a feature not seen in lichen planus. In view of the possible identical clinical and histological features of the two conditions it is necessary to establish a causal relation between the drug and the lichenoid eruption in order to exclude the diagnosis of coincidental lichen planus.

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Appearances of skin biopsy specimen from trunk. (H. and E. $\times 39$.)

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