Long-acting Synthetic Corticotrophin in Dermatology

Sir,—The latest paper by Dr. A. H. El-Shabouri (14 September, p. 653) showing that the long-acting synthetic corticotrophin Synacthen Depot is safe in patients sensitive to animal corticotrophin prompts me to describe our experience with its use in certain skin diseases.

Our interest was aroused by the work of Beser et al.3 in this hospital, who showed that it had equivalent potency but a longer duration of action than corticotrophin gel. This was confirmed by Dr. J. K. Nelson and colleagues (2 March, p. 557). Increasing the dose extends the duration of action. Our dosage has, therefore, varied between 0.5 and 2 mg. and our usual regimen has been 1 mg. twice weekly. We naturally started with problem cases, but have been sufficiently impressed with the results over the last few months that we are extending its use. A full publication is in prospect, but meanwhile the Table shows the results so far in the first six patients treated.

Table

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Diagnosis</th>
<th>Dosage</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Female, aged 60. Widespread purulent psoriasis</td>
<td>Initial dose 2 mg. Now receiving 1 mg. twice weekly</td>
<td>18 months history of purulent psoriasis treated in the past with oral steroids and oral methotrexate with little benefit. Marked improvement over palms and soles within 24 hours of her first injection of Synacthen Depot and now requires 1 mg. twice weekly as maintenance treatment. Obscuresia was noted after about 6 weeks therapy and she also showed increased skin pigmentation. Some improvement in hands within 48 hours of initial dose and has continued to improve over a period of weeks. Some discomfort noted at site of early injections. On and off oral steroids since 1959 and is still receiving 15 mg. prednisolone (1 mg. dose) while on Synacthen Depot. Definite improvement. Some pain at site of early injections Synacthen will be tailed off.</td>
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<tr>
<td>2.</td>
<td>Female, aged 70. Severe psoriasis with secondary spread</td>
<td>Initial dose 2 mg. Now receiving 0.5 mg. twice weekly</td>
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<tr>
<td>3.</td>
<td>Female, aged 27. Generalized erythematous psoriasis</td>
<td>Initial dose 2 mg. Now receiving 1 mg. twice weekly</td>
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</table>

Synacthen Depot is given by subcutaneous or preferably intramuscular injection into the buttck or thigh. Discomfort at the site of injection with the depot preparation seems to be less common when the intramuscular route is employed. Though this new preparation has advantages over natural corticotrophin and should prove useful in the acute and maintenance treatment of corticotrophi

can this help to improve the present pill?—I am, etc.,

Pinner, Middx.

R. G. R. GREENE-MATHERS.

REFERENCES

Response of Skin Conditions to Sympotms suggestiv of pyloric obstruction is typical. However, there are two points which might profitably be emphasized.

Plain radiographs of the abdomen may themselves be diagnostic of this condition, and will certainly indicate the necessity for barium meal. Gas may distend the duodenum and outline it as clearly as does barium. In one of our cases the principal features of intramural haemostoma, as described by Felson and Levin,4 were clearly demonstrated in this manner. Drs. Mindel and Kreil suggest that adequate x-ray studies may obviate the necessity for laparotomy. There are many reports which suggest that laparotomy should be performed immediately the diagnosis of intramural haemostoma is made1—4 in order to exclude concomitant undiagnosed injury, and to avert later complications. Having successfully managed two out of three patients conservatively, I agree that operation is not mandatory. However, the injury is, of course, much more extensive than the simple term intramural haemostoma4 would suggest. The patient must be kept under very close observation for many days, and if there are any doubts about all laparotomy should be performed. It is because of the extensive nature of the injury, and intramural haemostoma may be the central feature, that I would prefer the more non-committal term "duodeno-jejunal haemostoma" to describe this condition.—I am, etc.,

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REFERENCES

Duodenal Haemostoma

Sir,—I was interested to read the case report on duodenal haemostoma by Dr. S. Mindel and Dr. Louis Kreel (28 September, p. 785). I have seen three such cases2 and had never heard of this condition before. It seems to me that synacthen therapy might be useful in cases of this kind.

I would agree entirely that this is a recognizable clinical entity, which may be diagnosed radiologically. The history of a blow in the epigastrum followed 24 hours later by symp-