In the 15 cases of mycosis fungoides, a variable number of intraperdermal T-cells proved to react with HML-1. These cells were small isolated CD3+ cells with CD8+ or CD4+, CD8– phenotype. Subepidermal sheets of tumoural T-cells as well as tumoral T-cells in Pautrier’s abscesses, which were predominantly CD3+, CD4+ cells, were HML-1+. The lack of reactivity of HML-1 with Pautrier’s abscesses, also noted by Sperling et al., led us to conclude that mycosis fungoides tumour cells were HML-1+, and that HML-1+ intraperdermal lymphocytes, also observed in other benign inflammatory skin lesions (unpublished results), were likely to be lymphoid in nature.

Our results suggest that HML-1, used as a purified monoclonal antibody, is an interesting immunohistochemical marker for intestinal T-cell lymphomas, whether associated with enteropathy or not. This antibody, which reacts selectively with normal intestinal T-cell lymphomas, whether associated with enteropathy or not, and with HML-1– intraepidermal lymphocytes, also observed in other benign inflammatory skin lesions (unpublished results), could have been expected, our results do not provide evidence that mycosis fungoides cells are HML-1+. We thank Dr F. Berger, Dr M. Lasserre, and Dr G. Terres for providing three cases of intestinal T-cell malignant lymphomas.

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palm temperatures of the immersed hand were 9·6°C and 18·2°C, respectively. During the second minute of recovery, these temperatures rose to 10·2°C and 23·9°C, BP and heart rate had returned to pre-exposure levels (97/70 mm Hg, 65 beats/min).

However, atypical post-exposure features became apparent about 10 min after the cold immersion. The subject complained of severe throbbing pain in the immersed hand which became bright red and oedematous while remaining cold. He became extremely agitated and collapsed after a few minutes. At admission emergency to University Hospital he was incoherent, sweating, and hyperventilating, with BP 80/60 mm Hg and pulse rate 140 beats/min. Heart sounds were normal without symptoms of pulmonary oedema or cyanosis. The immersed hand remained red, cold, and swollen and the radial pulse was weak on the affected side. Intravenous diazepam (10 mg) was given and the affected hand was raised on a sling. After 2 hours sleep the patient behaved normally. The pain and swelling in the affected hand had subsided. Sensations were intact with motor functions impaired by oedema in the affected hand. The oedema continued to subside and the subject was discharged the following day. The patient had mild pain and swelling in the hand for a further 4 days, and residual mild wrist joint pain persists 2 months after the incident.

The cold water hand immersion procedure has been widely used in studies of the cutaneous vascular circulation and of responsiveness to hand cooling in populations from temperate, cold, and warm climates. Cold-induced injury has not been recorded in these investigations. Mechanisms responsible for the inflammation and oedema seen in our subject are thought to have neurogenic and autocrine components. Local cooling of arterial regions produces intense constriction in arterial and venous vessels via direct and reflex pathways. The local hypoxia is thought to result in the production and release of endogenous vasocactive substances, such as histamine, prostaglandins, and substance P, causing localised vasoconstriction and increased capillary permeability. However, the cyclic constriction and dilatation ("hunting phenomenon") elicited by tissue injury resulting from severe cold exposure was not apparent in our patient. The other symptoms reported here were probably caused by pain and anxiety. Investigators should be aware of the possibility of cold injury to mild cold exposures in susceptible individuals.

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PREDICTION OF POOR OUTCOME OF CUTANEOUS SURGERY

Sir,—Most patients' complaints after plastic surgery stem from the poor outcome of their scars. In Ehlers-Danlos syndrome poor wound healing and devastating "cigarette paper" scars are usual. A milder variant of the classic form of Ehlers-Danlos syndrome may be commoner in the general population than previously thought, and may be easily identified by a simple clinical scoring system. We have used this clinical scoring system to predict the outcome of surgical scars in the general population.

35 men and 51 women, aged nineteen to fifty-four years, were investigated. None was on any oral medication known to interfere with collagen synthesis or metabolism (anticoagulants, corticosteroids, phenytoin, d-penicillamine, antineoplastic agents, phenylbutazone). From three months to one year before the study, patients had undergone surgery for cutaneous surgery for naevi, dermatofibromas, cysts, and minor neoplasms. Surgery was done by the same plastic surgeon who followed Langer's skin tension lines. The suture stitches had been removed five days after surgery to the face and seven to ten days for other regions. Scars were classified blind as barely visible, dyschromic, depressed, or atrophic, keloidal, and diastatic. The patients were also scored clinically according to Holzberg and colleagues' system as follows. Joint hypermobility (score 1 point for each): (a) dorsiflexion of little finger over 90° with forearm flat on the table, (b) passive apposition of thumb to flexor forearm, (c) hyperextension of elbow over 10°, (d) hyperextension of knee over 10°, and (e) forward flexion of trunk so that palms of hand rest easily on floor.

Skin extensibility: skin of ventral left forearm lifted midway between the elbow and wrist (measure distance skin is stretched); (score 0 for under 4 cm, 1 for 4 cm, 2 for 5 cm, 3 for 6 cm, 4 for 7 cm, 5 for 8 cm).

Cigarette paper, wrinkled scarring (score for each of 5 bony points): (a) left elbow and forearm, (b) right elbow and forearm, (c) left knee, (d) right knee, and (e) forehead.

Bruising (score 0 to 5): (a) 0 = no history or clinical evidence, (b) 1 = positive history of mild bruising, no clinical evidence, (c) 2 = positive history of moderate bruising with or without skin findings, (d) 3 = moderate bruising on physical examination, (e) 4 = pronounced bruising on physical examination, and (f) 5 = gross bruising on physical examination.

58 patients had a good scar (ie, barely visible or just dyschromic), whereas 28 complained of bad results: namely, hypertrophic (12), depressed or atrophic (13), and diastatic scars (3). All 58 patients with regular, barely visible, or dyschromic scars had a score of 2 or lower. 10 patients with hypertrophic scars had a score of 3 or greater and the remaining 2 had a score of 2. 12 patients with depressed or atrophic scars had a score of 3 or greater and only 1 had a score of 2. Among patients with diastasis of wound edges, 2 had a score of 5 and 1 had a score of 1. The differences were significant (chi-squared test, p < 0.0005).

Atrophic and diastatic scars were prevalent among patients with high scores. At score 2 or higher, scars tended to be poor and, importantly, only in 4 patients with a score below 2 was the scar acceptable. Thus the outcome of scarring is easily predictable by means of a simple scoring system based on clinical examination.

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SALICYLIC ACID AND ULTRAVIOLET B FOR PSORIASIS

Sir,—After salicylic acid was synthesised in 1874 it soon became the most widely used keratolytic agent for the treatment of scaling skin disorders such as psoriasis. Today it is still used by patients with psoriasis to remove scales, either as a sole remedy or before other external therapy. In 1925 Goeckerman described combination therapy with crude coal tar and ultraviolet light (UV), and phototherapy is now part of the standard therapeutic armamentarium for psoriasis. The advent of photochemotherapy with psoralsens and UVA (PUVA) more than a decade ago led to a resurgence of interest in UVB (280-320 nm) as monotherapy, 80-90% of psoriasis patients improve considerably or clearly complete after a series of UVB exposures, and UVB is an increasingly used treatment that is especially convenient for outpatients. During the early days of sun protection salicylic acid derivatives such as homomenthol and 2-ethylhexyl salicylate were commonly used in sunscreens. Growing awareness of the dangers of sun exposure to the skin led to their withdrawal from sunscreen formulations in the 1980s. Today, salicylic acid is used in sunscreens in a few countries to counteract potential effects of UV on the skin.

Sir,—We report the use of salicylic acid (8% w/v emulsion, 1× daily for 2 weeks) and UVB (7 J/cm² at 330-380 nm, twice weekly) in 10 patients with classic psoriasis vulgaris (18% body involvement). Salicylic acid was chosen for its keratolytic effect, and UVB for its immunomodulatory activity. The patients were all over 40 years. The mean disease duration was 17 years, and the mean Psoriasis Area and Severity Index (PASI) score was 16. After a 4-week wash-out period, both drugs were applied simultaneously to different body areas. The mean PASI score fell from 16·3 to 6·7 (p < 0·001). The most remarkable side effects were mild burning on the skin and increased sun sensitivity. Thus these results show that the combination of salicylic acid and UVB is an easy and effective treatment for patients with psoriasis vulgaris.