AZATHIOPRINE AS A CORTICOSTEROID SPARING AGENT IN CHRONIC ACTINIC DERMATITIS

(Report of Three Cases)

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Introduction

Chronic actinic dermatitis (CAD) is a relatively new descriptive term for severe, recurrent form of photosensitivity occurring in middle aged and elderly persons [1]. Affected patients present with confluent eczematous lesions most marked in but not limited to the sun exposed skin [1]. Others have marked lymphoma-like induration and infiltration of actinic reticuloid [3]. Topical/systemic steroids are the mainstay of therapy but continuous use over a prolonged period often leads to major side effects [4]. Herein we report our experience of use of Azathioprine as a corticosteroid sparing agent in three cases of CAD.

Case-1

A 56-year-old farmer presented with widespread scaly infiltrated plaques over the face, ears, scalp, sides of neck, V of chest and dorsa of hands and feet for the past 10 years. There was accentuation of skin markings on the face with a tendency to leonine facies. Hair of eyebrows and eyelashes were lost. Scalp hair were short and stubby (Fig 1). The lesions were present throughout the year with exacerbation in summer months. He had been on regular therapy with topical steroids and sunscreens but the acute phase necessitated use of oral steroids to achieve remission. In Oct '97 he developed bacterial septicemia necessitating parenteral antibiotic therapy and tapering off of oral prednisolone. However, the cutaneous lesions flared with marked erythema, induration and pruritis.

Azathioprine (100 mg/day) was initiated alongwith other measures. 50% clearing of lesions was achieved after 4 weeks of therapy and almost complete remission after 3 months of therapy (Fig 2). Dose was reduced to 50 mg/day at this stage. However, the lesions reappeared on the face and neck with 30% severity of the original disease.

Case-2

A 66-year-old housewife presented with eczematous lesions on the face, 'V' of neck, dorsa of hands and forearms for the past 7 years. She developed oozing and crusting with severe pruritus on every exacerbation. Erythema and infiltration of the skin most

marked over the exposed areas was seen. She had associated diabetes mellitus well controlled with oral hypoglycemic agents. When her conditions proved difficult to control with topical therapy, Azathioprine 100 mg/day was introduced with good response. Follow up at 4 weeks permitted a reduction of dosage to 50 mg/day with no relapse seen on stopping the drug after 12 weeks course. No side effects of the drug were detected.

Case-3

A 68-year-old car mechanic presented with scaly lichenified plaques and accentuated skin markings on the face of 4 years

Fig 1 : Before treatment with Azathioprine

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Fig 2 : Same patient after treatment with Azathioprine

duration. History of aggravation of cutaneous lesions on exposure to light was present. He developed acute exacerbation with erythema and infiltration over large patches of skin on the upper back, chest and abdomen. These proved difficult to control despite systemic corticosteroids and topical therapy. Azathioprine 100 mg/day was started and oral corticosteroids tapered off over a 3 week period. In 6 weeks, the patient achieved good remission permitting the dose to be reduced. After 12 weeks, Azathioprine was stopped with no relapse.

Discussion

Immunosuppressives have been used earlier for management of this virtually intractable disorder [5]. The probable mechanism of action is depletion of cutaneous Langerhans cells leading to a muted immune response [6]. In our patients, a 6-12 week course of Immuran coupled with topical therapy significantly reduced the pruritis and cutaneous lesions. Two patients had complete clearing of lesions while in the third, the dermatitis relapsed on reducing the dose. No significant adverse effects were noted.

Although the study group is small, the good response to Azathioprine elicited in our patients suggests that it should be included in the treatment protocol of this debilitating condition.

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