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Title: **ITP & Skin Irritation**

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[We had received letters from Platelet readers asking for advice about skin irritation (pruritus). This is not a condition normally associated with ITP, but since a number of readers raised questions which we felt were worth answering we asked Dr. Nigel Burrows, Consultant Dermatologist at Addenbrooke's Hospital, to address our readers' queries in a feature specifically devoted to skin conditions.]

Do steroids (such as prednisolone) cause skin irritation, and what is their effect on the skin generally? Can anything be done to prevent or reverse skin irritation or damage?

The main effect of oral steroids on the skin are impaired wound healing, thinning of the skin (atrophy), bruising, stretch marks (straiæ), telangiectasia (redness), and acne. Steroids are a very useful treatment for pruritic skin conditions. I did look through the literature however and was interested to come across a report in the Journal of Rheumatology in 1998 where they reported pruritus as a side effect in 4% of patients receiving high-dose intermittent intravenous corticosteroids in children with rheumatic diseases. This is clearly a different situation from your patients.

Does iron deficiency (sometimes found in woman who have heavy periods with ITP) and/ or vitamin B deficiency cause skin irritation, and if so would a blood test show up a deficiency of the latter?

There is felt to be an association between lack of iron stores in the body and pruritus, but I am not aware of any link with vitamin B.

Are any of the following drugs known to cause skin irritation and if so can anything be done in mitigation:– azathioprine; cyclosporin; penicillin V (taken daily by asplenic patients)?

I am not aware of Azathioprine causing pruritus, although very occasionally (in less than 2%) pruritus has been reported with Cyclosporin. It would be extremely unusual for Penicillin V to cause pruritus without an associated drug rash.

Are sufferers of autoimmune disorders more prone to eczema? Can mild eczema produce itching without visible symptoms that may not be recognised by a doctor?

I am not aware of sufferers of autoimmune diseases being more prone to eczema, although I am sure you will be aware of a condition called Wiskott-Aldrich Syndrome. This is an x-linked disorder associated with thrombocytopenia, eczema and infections. The gene has been found for this syndrome and the patients have impaired immune functions.

Mild eczema will present usually as patches of dry skin which would be visible to the naked eye, and therefore recognised by a doctor and treated appropriately with emollients.

If no cause can be found for skin irritation, have you any suggestions on how to suppress it?

General measures helpful for pruritus are emollients such as Aqueous cream, or 2% Menthol can be added to the Aqueous cream to increase the soothing effect. Other

commercially available preparations include Balneum cream, and a newer cream on the market - xepin cream, but this can only be used to less than 10% of the body surface areas at one time. Finally, there is an undoubted association between polycythæmia rubra vera and pruritus, but I could not find any literature on thrombocytopenia and pruritus. Ω