Treatment of acquired perforating dermatosis with colchicine

Sir,

With reference to the therapy letter, "Successful treatment of acquired perforating dermatosis with colchicine" by Gil *et al*.,[1] we read with great interest the successful management of a difficult to treat condition. The authors reported a patient of acquired perforating dermatosis (APD) without any underlying comorbidity, who had no response to 1 month of high potency topical corticosteroids, but responded to addition of colchicine 1 mg twice daily (i.e., 2mg/day). The lesions improved rapidly, with significant reduction of pruritus, and resolution of lesions with residual post-inflammatory hyperpigmentation after 2 months of treatment. We wish to inform that we had also reported appreciable response to colchicine.[2] Our patient had unresponsive APD but with comorbidities in the form of type 2 diabetes mellitus and chronic kidney disease.[2] A rapid response was seen within 4 weeks, both in terms of reduction in itching and flattening of lesions. However, we had used a lower dose of colchicine (1 mg/day) in view of the underlying renal disease and succeeded. As patients with APD often have comorbidities and renal compromise,[3] we wish to highlight that even lower doses of colchicine may be effective.

The possible mechanisms of action of colchicine have been well elucidated by Gil *et al*.[1] It includes downregulation of multiple inflammatory pathways, inhibition of microtubule formation, antifibrotic properties via inhibition of fibronectin and transforming growth factor-β1, and interference with leukocyte migration, adhesion, and degranulation.[4,5] It is a useful drug in the therapeutic armamentarium for many neutrophilic dermatoses.[4]Also, low dose colchicine has been found to be efficacious in treating pyoderma gangrenosum.[6] However, it should be kept in mind that the most common side effects which include nausea, vomiting, and diarrhea can be severe at times, even at recommended doses leading to drug discontinuation.[4] In addition to this, the uncommon side effects can be quite serious and life threatening at times like arrhythmias and bone marrow suppression, hence it may not be recommended as first-line therapy in all cases.

Additional points of interest in the report by Gil *et al.* include the unilaterality of lesions, presence of larger ulcerated plaques with a necrotic dirty-looking floor, and a central eschar rather than a keratotic plug in most of the lesions shown.[1] We wonder if there were other pathologies at play in their case, including infectious causes.

In view of the dramatic response to therapy seen with the above reports,[1,2] we would like to suggest that colchicine could be an effective treatment option in the management of a difficult dermatosis like APD. Low dose (1mg/day) may be considered as a starting dose, especially in patients with underlying renal disease and dose escalation may be considered slowly. APD is not an uncommon dermatosis, and more reports in this direction could help decide optimum treatment regimes.

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Conflicts of interest

There are no conflicts of interest.

Geetali Kharghoria, Chander Grover[1]

Department of Dermatology and Venereology, All India Institute of Medical Sciences, [1]Department of Dermatology and Venereology, University College of Medical Sciences and Guru Teg Bahadur Hospital, Delhi, India

Address for correspondence:
Dr. Chander Grover,
Professor, Dermatology and STD, UCMS and GTB Hospital,
Delhi - 110 095, India.
E-mail: chandergroverkubba@rediffmail.com

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