face, although the simultaneous existence of these two lesions is uncommon.

The case presented herein shows that the BCC of the skin which lines the surface of a hemangioma can develop not only as a result of previous radiation or other intervention, but in the absence of such treatment as well.

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Valaciclovir in secondary and tertiary cases of adult chickenpox

To the Editor: I would like to report the use of valaciclovir in a secondary and tertiary case of adult chickenpox occuring in the same family. This is the first report of the use of this compound in adult chickenpox. While chickenpox is usually a benign illness in young children it can be quite a severe illness in young adults [1,2]. Acyclovir when used in family members during the exposure or during the early stage of the rash has being shown to significantly attenuate the disease and it is strongly recommended that young adults who are exposed to the virus should be started on acyclovir [3,4]. One of the disadvantages of acyclovir is its limited (or poor) absorption and the fact that it has to be taken five times daily.

Valaciclovir is a pro-drug of acyclovir. When taken orally it provides over four times the bioavailability of oral acyclovir. Valaciclovir has a bioavailability of 54% as against 12% for that of 800 mg acyclovir and gives plasma concentrations of acyclovir comparable to those obtained with intravenous acyclovir therapy [5].

Because of this higher acyclovir bioavailability valaciclovir is already established as a front line drug for the treatment of Herpes Zoster. Recently we had the opportunity of observing the effect of valaciclovir in secondary and tertiary adult cases of chickenpox in the same family.

The first member in the family, a girl of 22, developed a classical chickenpox rash. The rash was very widespread and 4 months after the rash has subsided her face is still very marked with over a dozen excoriated ulcerated cratered areas still remaining.

She had two younger brothers one of 20 and one of 18 and it was decided that should they develop varicella that they should start on valaciclovir. Ten days later her 20 year old brother developed the classical rash of chickenpox. He initially spiked a fever of 38.5°C on day one of his illness. Associated with the temperature he had headaches.

He was cold and shivery. He developed spots on his chest and back on day one. Valaciclovir 1000 mg tds was initiated on day one of the rash presenting and continued for 5 days.

Further spots developed on both sides of the face and lower arms. His temperature was 38°. He was

able to take drinks but had no appetite for food. New spots stopped appearing from 36 h after the onset of the rash. On day 3 his temperature was normal and he was feeling much stronger. On day 4 he was feeling much improved. No further rash appeared and the spots that had formed continued to heal rapidly over the next week. Two and a half days after the rash had begun the spots began to heal. He had no major systemic complications of chickenpox and the therapy was very well tolerated.

The third offspring in the family was a boy of 18. He was watched closely for the development of any spots. The first spot was also noticed at 11.00 o'clock on the same day that the number two offspring had begun his systemic symptoms. At mid-day when further spots had appeared on his abdomen, chest and back valaciclovir was begun. The third case also complained of pain on the left hand side of his chest. The next morning the spots had developed into vesicles and some other spots had developed on his back. The next morning his temperature was mildly elevated at 37.4°. He was complaining of some pains in his back and limbs. He remained apyrexial for the reminder of his illness. No new spots appeared after the second day. Other spots began to heal rapidly from then on.

Normally the secondary and tertiary cases of adult chickenpox increase in severity when compared with the initial index case [4].

In this instance the disease was the mildest in the third case. Initially the second case showed quite marked severe symptoms but these rapidly abated once valaciclovir was started.

Neither the second or tertiary case were left with facial lesions or scars in contrast with the first index case. We therefore feel that this family case study of the open use of valaciclovir appears to show that valaciclovir has very promising potential as a front-line therapy in adult chickenpox and a more extensive study of this drug in this condition is indicated.

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Should we limit the use of terbinafine to the treatment of wide-spread dermatophytosis?

To the Editor: 12 patients (5 males and 7 females, 23–79 years of age) with a dermatomycosis duration ranging from 2 months to 5 years were recruited for the study.

In all patients the dermatomycosis was diffuse, with simultaneous involvement of multiple skin areas. Common lesion sites were the trunk, limbs, face and buttocks (Table 2). Hair involvement was present in all cases but often could not be detected clinically although it was constantly documented by microscopic examination.

Clinical diagnosis was regularly confirmed by accurate mycological tests, both fresh and in Sabouraud's agar, which made it possible to isolate *T. rubrum* in 5 cases, *T. mentagrophytes* in 4 cases and *M. canis* in 3 cases.

After obtaining formal consent from all patients, terbinafine was administered orally at a single daily dose of 250 mg for 30 days.

Clinical and mycological control was carried out once a week during therapy and the one month follow-up period.

The main hematochemical and urinary parameters where evaluated at the beginning and at the end of the therapy.