League of Dermatological Societies and its Committee on Nomenclature.  

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Evaluation of Therapeutic Success of Hyperhidrosis Therapy

We read with interest the article by Karamfilov et al suggesting lower relapse rates of hyperhidrosis after high-dose botulinum toxin type A injections (BOTOX; Allergan Inc, Irvine, Calif; hereinafter, genetically, botulinum toxin A). Various protocols for treating hyperhidrosis with botulinum toxin A have been issued empirically without controlled comparison of doses, dilutions, number of injections, or pharmaceutical products. Thus, any attempt to provide evidence-based information on how to optimize botulinum toxin A treatment should be welcomed. For this purpose, however, stringent study designs, accurate measurements of sweating, and uniform follow-up schedules are indispensable. Unfortunately, Karamfilov et al did not implement a control group receiving low-dose botulinum toxin A, which could have been easily provided by a left-vs-right comparison, with each patient being his own control.

Also, the iodine-starch test and planometry, which are helpful to visualize the active hyperhidrotic area, are not pertinent for exact quantification of sweating. In fact, positive findings on the iodine-starch test easily occur in any healthy individual. It is, however, the rate of sweating (amount per minute) that makes a person hyperhidrotic, and this can accurately be determined by gravimetry using blotting paper, a high precision scale, and a stopwatch. In 156 patients recently screened for severe axillary hyperhidrosis, the mean ± SD active area as visualized by the iodine-starch test was 48.5 ± 4.4 cm², ranging from 14.2 to 66.5 cm², which showed no correlation to actual sweat rates measured by gravimetry (52-858 mg/min). The fact that gravimetric values may vary considerably does not discredit this method but rather demonstrates the dynamics of eccrine glands in hyperhidrosis. After botulinum toxin A treatment, gravimetric sweat rates have been shown to be consistently low.23

Follow-up as reported by Karamfilov et al ranged from 5 to 15 months, but it remained unclear at what intervals patients were observed—if there was any regular follow-up schedule at all. Waiting for the patient to ask for subsequent treatment is definitely too volatile a parameter for a clinical study, especially when trying to establish measurable benefits compared with already existing protocols. Finally, but not of least importance, the safety of high-dose botulinum toxin A as proclaimed by Karamfilov et al is questionable; the authors failed to mention that the risk of antibody induction rises not only with treatment frequency but also particularly with higher doses.

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The Wheal: To Be or Not to Be

Sad to say, until a dictionary of dermatology equivalent to the Oxford English Dictionary comes into being, dermatology will forever be a twugle imposter, rather than an authentic branch of knowledge.

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It is astonishing that the current significantly different meanings of the term cutaneous elementary lesions have received so little attention in dermatology journals. But it is precisely for this reason that the renewed controversy regarding basic dermatological lesions reflected in the ARCHIVES holds great interest.4 The suggested elimination of wheal "from the list of basic terms" is worthy of comment. In our opinion, there are also reasons favoring its preservation on such a list. Dermatologists have traditionally used a specific term to describe lesions of urticaria except in French dermatology. The analysis of such a tradition may contribute to a better understanding of this controversy.

English Tradition. Wheal is an Anglo-Saxon word. Robert Willan and Thomas Bateman turned this into a spe-