



LETTERS TO THE EDITORS

Dear Editor,

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Plant products for practising procedural dermatology

Procedures form an inextricable part of the dermatologist's practice. When first undertaking a new procedure, novices are often daunted by the steep learning curve in the first few months, an experience we (the authors) empathise with. The use of fruit and vegetables may lessen some of the stress and enhance a sense of fulfilment in the nascent proceduralist. Bananas, the most popular fruit in the Western world, provide a readily available curved surface with intrinsic layers on which newly appointed registrars can practise suturing. Mohs fellows can practise removing surgical 'debulks' and taking bevelled, uniformly thin Mohs layers,¹ an initially alien concept to the recently graduated dermatology registrar that will become increasingly familiar during their training. For the new laser practitioner, aubergines provide a ready source of water-rich material that provides an ideal medium on which to practise ablative laser surgery, including with devices such as the carbon dioxide laser. The purple skin of the aubergine provides a clearly visible surface that can be ablated and give an indication of the depth of penetration and the extent of fractionation. Furthermore, aubergines do not tend to explode on being vaporised – an important, pragmatic advantage of this vegetable. Plant-procured products can provide a cheap, accessible, less pungent alternative to porcine skin and synthetic models and can hugely improve the experience of procedural dermatologists. We suggest those learning new procedures (and their trainers) consider these tools to augment their learning.

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Conflict of interest: none

Dear Editor,

Fixed drug eruption probably induced by azithromycin

Fixed drug eruption (FDE) is a cutaneous drug reaction leading to the recurrent appearance of erythematous and bullous skin lesions at the same sites each time the offending drug is administered.¹ Azithromycin is a macrolide antibiotic and is used in lower respiratory infections and skin infections.² In this report, we present a patient who developed FDE after using azithromycin for acute tonsillitis.

A 50-year-old female patient presented with erythematous lesions on the anterior aspect of both legs. The patient had no history of chronic disease and had been given azithromycin due to acute tonsillitis 3 days prior. Apart from azithromycin, the patient had no history of drug use. After using azithromycin for 1 day, she noticed a burning sensation and pruritus on both legs, followed by erythematous patch-like eruptions. Examination revealed multiple, sharply demarcated erythematous eruptions of varying sizes on both legs (Fig. 1). The patient's history revealed a similar eruption 2 years earlier following a course of azithromycin for a throat infection. This resolved with hyperpigmentation.

FDE often occurs within several hours or days after the administration of the offending drug.^{3,4} More than 100 aetiological agents have been associated with FDE, including sulphonamides, nonsteroidal anti-inflammatory drugs, tetracyclines and carbamazepine.^{1,3,5} The diagnosis of FDE is established clinically. In addition, a histopathological examination may also be performed.³ Re-exposing the patient to the suspected drug may confirm the offending drug; however, this test is unethical and is not recommended. A number of causality assessment scales for drug reaction have been developed, including the Naranjo adverse drug reaction probability scale, the World Health Organization Uppsala Monitoring Centre causality assessment system, and the Hartwig scale.⁵ Our patient refused to have a skin biopsy. Oral provocation test was not performed due to the risk of generalized eruption. Using the Naranjo scale (Naranjo's score = 7), azithromycin was thought the probable cause. The severity of the FDE was graded as moderate based on the modified Hartwig and

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