component of CD can explained the cutaneous vasculopathy and the inflammatory and ulcerated lesions. MCD is a well suited name for this form.

The intertriginous and genital MCD present frequently as an isolated, indurated oedema associated with rhagades. This infiltrated oedematous MCD would correspond to the presence of the non-caseating tuberculoid granuloma without or minimal vascular injury. For this form, often associated with an anoperineal CD, the term MCD is confused and we suggest to use oedematous cutaneous CD instead.

References

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LETTERS TO THE EDITOR

Treatment of post-inflammatory hyperpigmentation using 1064-nm Q-switched Nd:YAG laser with low fluence: report of three cases

Editor
A 58-year-old Korean male patient presented with several discrete brownish pigmented macules on the face. One month prior to the visit, the patient performed Q-switched ruby laser therapy due to senile lentigines at a private clinic, leading to the development of the pigmented lesions. Although he was prescribed a bleaching agent, satisfactory improvement could not be achieved.

Five sessions of 1064-nm Q-switched Nd:YAG laser (QSNY) treatment using MedLite C6™ (HoyaConBio Inc., Fremont, CA) with low fluence were delivered weekly. The entire face was treated with the settings of 1.9–2.6 J/cm², 6-mm spot size, and three passes with appropriate overlapping. Additional treatment on the PIH was directly followed with the same settings two passes with appropriate overlapping. The patient did not present major complications or side-effects. The patient’s PIH had not recurred even after 2 months following the final treatment.

A 39-year-old Korean female patient presented with several discrete brownish pigmented macules on the face. Two sessions of intense-pulse light (IPL) and one session of QSNY therapy due to unspecified pigmentary disorders was performed at a private clinic 6 months ago. Soon after the QSNY procedure, the brownish lesions had developed and did not regress spontaneously (Fig. 1a).

Five sessions of 1064-nm QSNY with low fluence were delivered weekly. The entire face, including PIH, was treated with the settings of 1.9 J/cm², 6-mm spot size. Additional two passes of treatment on the PIH was directly followed with the same settings. The patient did not present major side-effects. The patient’s PIH remained at an improved state 2 months after the final treatment (Fig. 1b).

A 31-year-old Korean female patient presented with several discrete and mottled brownish pigmented macules on the face. Three sessions of IPL and QSNY therapy due to freckles was performed at a private clinic 4 months ago, and after the procedure, the pigmented lesions began to develop. The patient was given bleaching agents and several sessions of vitamin C iontophoresis for the brownish macules. However, noticeable improvement could not be achieved.

Five sessions of 1064-nm QSNY with low fluence were delivered weekly as the second patient. The patient did not present major side-effects. The treated lesions maintained an improved state for over 2 months following the last treatment.

Pigmentation abnormalities developing after cosmetic procedures, such as chemical peeling and laser therapies, are always a concern, especially in Asians. Some cases of PIH tend to be spontaneously regressed; however, certain forms of PIH need to be treated with several therapeutic attempts, including bleaching creams, several kinds of Q-switched lasers, erbium-doped fractional photothermolysis system, with various treatment outcomes. Park et al. postulated that repetitive IPL treatments following low fluence Q-switched ruby laser decreases the risk of potential PIH caused by Q-switched ruby laser therapy. A 1064-nm QSNY with low fluence therapy is easily applicable and the therapeutic trial in our case was revealed to have minimal downtime without post-therapy bleeding or crust formation, and the post-therapy erythema spontaneously resolved within a few hours.
Increased melanin pigments, histologic features of PIH,\(^2\) could be the chromogens involved during the 1064-nm QSNY low-fluence treatment. Although epidermal pigments or melanocytes are usually more sensitive to 532 nm than 1064 nm,\(^3\) considering the risk of post-therapy dyschromia by 532-nm QSNY itself, we believe that 1064-nm QSNY with low-fluence treatment should be considered in the treatment of PIH. However, the precise mechanism of therapeutic effects on PIH or risk reduction of PIH formation by the 1064-nm QSNY with low fluence still remains to be elucidated.

**References**


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**Oral fixed drug eruption caused by gabapentin**

**Editor**

Fixed drug eruption (FDE) is a distinct variety of drug induced dermatoses with characteristic recurrence at the same site of skin or mucous membrane.\(^1\) Literature is silent on cutaneous adverse effects caused by gabapentin except one case report of cutaneous leucocytoclastic vasculitis.\(^2\) We hereby, report a case of bullous FDE caused by gabapentin, an anticonvulsant drug.

A 44-year-old male patient presented with post herpetic neuralgia. On evaluation, patient recalled history of epileptic fit 2.5 years ago and developed severe cutaneous eruptions after taking some anticonvulsant drug. Past medical records of treatment of epileptic fit could not be traced. As phenytoin or carbamazepine was thought to be the offending drug, these were not prescribed for post-herpetic