To the editor:

Treatment of painful sickle cell leg ulcers with topical opioids

Leg ulceration is a common and painful complication of sickle cell anemia (SS). Leg ulcers tend to be indolent and intractable and heal slowly over months or years. The pain of these ulcers may be severe, excruciating, penetrating, sharp, and stinging in nature. In most patients, oral or parenteral opioid analgesics may be needed to achieve some pain relief. We wish to report our experience with 2 patients with SS and painful leg ulcers who achieved total pain relief with the applications of topical opioids, thus decreasing the amount of oral opioids taken to control the pain.

A 38-year-old African American woman with SS developed a painful 3.5 cm–by–3.5 cm ulcer on the medial aspect of the right ankle. The pain was excruciating, stinging, and sharp in nature with an intensity score of 10 on a 0 to 10 numerical verbal scale. The pain was worst at night, woke her up frequently, and required treatment with 5 mg oxycodone every 2 to 3 hours. She consumed 16 to 18 tablets of oxycodone per day, most of which were at night. The pain forced her to walk with a limp and interfered with her activities of daily living. In an effort to control the ulcer pain, one tablet of oxycodone was dissolved in 1 to 2 mL water and applied to the leg ulcer topically after mixing with the debridement ointment that she was using. This gave her almost immediate pain relief, decreased the intensity of the pain to 0, and reduced oxycodone consumption to 0 to 2 tablets per day.

The second patient was a 67-year-old African American woman with SS and chronic bilateral painful ulcers on both ankles for more than 20 years. The pain was stinging and sharp in nature and was managed with 100 mg meperidine orally every 2 hours as needed and topical xylocaine ointment, with some relief. Measures to treat the ulcers including transfusion, grafting, debridement, hyperbaric oxygen, and growth factor therapy failed to induce healing. In an effort to achieve better pain relief, one 100 mg meperidine tablet was dissolved in water and applied to the ulcers with the xylocaine ointment. This gave her almost immediate pain relief, with a longer lasting effect than oral meperidine, and decreased the amount of meperidine consumed per day.

Our experience with these 2 patients indicate that topical opioids may be of value in relieving the pain of SS leg ulcers and decreasing the amount of oral opioids taken to achieve pain relief. These findings also indicate that peripheral opioid receptors do mediate peripheral analgesia.[1] Topical morphine has been reported to relieve the pain of decubitus skin ulcers in cancer patients.[2,3] To the best of my knowledge, this report is the first to show the efficacy of topical opioids in sickle cell leg ulcers and that opioids other than morphine are also effective.

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References

1. Levine JD, Taiwo YO. Involvement of the mu-opiate receptor in peripheral analgesia. Neuroscience. 1989;32:571-575.
2. Krajnik M, Zylicz Z, Finley I, Luczak J, Van Sorge AA. Potential uses of topical opioids in palliative care - report of 6 cases. Pain. 1999;80:121-125.
3. Twillman RK, Long TD, Cathers TA, Mueller DW. Treatment of painful skin ulcers with topical opioids. J Pain Symptom Mgmt. 1999;17:288-292.

To the editor:

Sustained response of refractory chronic lymphocytic leukemia in progression complicated by acute hemolitic anemia to anti-CD20 monoclonal antibody

We have read with interest the paper of Huhn et al on rituximab therapy of patients with B-cell chronic lymphocytic leukemia (CLL).[1] Seven of 28 heavily pretreated patients showed a partial remission (NCI criteria), lasting for a median of 20 weeks. Huhn et al conclude that rituximab as a single agent might play a role in patients with poor marrow reserve for whom other options have failed. We would like to comment on the role of this therapy in refractory patients with concomitant acute hemolitic anemia (AHA). About 4% of CLL patients develop AHA,[2] mainly in those with active disease, and few data exist regarding the efficacy and safety of rituximab in this clinical setting.[3]

We recently employed rituximab as rescue therapy for a patient with resistant B-cell chronic lymphocytic leukemia (B-CLL) and secondary AHA. A 52-year-old patient, diagnosed in January 1996 as having stage Rai II classical B-CLL, was admitted to our department after 24 months in disease progression (huge splenomegaly, anemia, and lymphocyte count above 50 000/μL) complicated by AHA (warm antibody type). Thereafter, he was given the following therapy: chlorambucil and prednisone, fludarabine+mitoxantrone+dexamethasone (FND), and cyclophosphamide+adriamycin+vincristine+prednisone (CHOP). After each line of therapy the patient attained only a short (less than 6 months') partial remission (PR), followed by tumor regrowth (splenomegaly, lymphocytosis, and anemia). In August 2000 he was admitted to our department again for disease progression. Physical examination revealed overt jaundice and hepato- and splenomegaly (15 cm below costal margin). Laboratory data were as follows: hematocrit, 21.3%; hemoglobin level, 6.6 g/dL; reticulocyte count, 320×10^9/L; mean corpuscular volume, 106 fL; platelet count, 166×10^9/L; white blood cell count, 32×10^9/L with 38% lymphocytes, 50% prolymphocytes, and 12% neutrophils; bilirubin level, 35 μM; lactate dehydrogenase level, 894 IU/L (normal is below 460 IU/L); and a direct antiglobulin test (DAT) positive for both complement (3+/4+) and IgG (4+/4+). The immunophenotype of peripheral blood lymphoid cells showed a typical B-CLL pattern ($CD19^+/CD5^+/CD23^+/CD10^-$) with unusual CD20 bright fluorescence intensity. He was naïve for hepatitis viruses and