bited after 1 month of treatment with CyA as cellular expression of interleukin-2 receptor (CD25) was slightly decreased. The increase in HLA-DR may also be due to the increase in CD1+ cells expressing HLA-DR.

The mode of action of cyclosporin in this condition is unknown but, whilst negative immunofluorescence makes a humoral autoimmune mechanism unlikely, the response to cyclosporin and the abundance of T lymphocytes in the dermal infiltrate (not previously reported in the literature) suggest that these cells play an important pathogenic role. The effects of CyA on the infiltrate are very similar to those demonstrated in psoriasis treated with CyA7 with a diminution in the T-cell infiltrate that was most marked for CD4+ (T helper) cells and an increase in CD1+ (Langerhans) cells in the epidermis after treatment. The epidermal defect with acantholysis was still present after clinical resolution of lesions and in vitro epidermal tissue cultures from affected patients reveal similar changes when removed from dermal influences.8,9 We postulate a basic defect in cell adhesion throughout the skin of these patients. The disease only manifests when external factors such as friction, occlusion or infection provoke cytokine release and a lymphocytic inflammatory response.

The 'dilapidated brick wall' appearance seen on histology may offer a very easy route for the penetration of CyA and yet we were unable to produce a response by this route. Our experience suggests that this drug merits further evaluation in patients with severe and recalcitrant Hailey-Hailey disease.

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