children about the same. These results suggest that other factors, such as host resistance, rather than the pathogenic property of enterotoxin production determine whether intestinal contamination by C. jejuni is associated with gastrointestinal symptoms.

Welcome Research Unit, Christian Medical College Hospital, Vellore 632 004, India

Department of Medicine, University of Rochester, Rochester, N Y 14642, USA


**Cyclosporin for Psoriasis**

Sir,—In 1979, Mueller and Herrmann used cyclosporin to treat four patients with severe psoriasis and noted that the psoriatic plaques "almost disappeared" five days after starting treatment, but gradually reappeared when treatment stopped, only to resolve again when the treatment was restarted. We report the case of a 56-year-old man with extensive chronic plaque psoriasis, crippled by severe psoriatic arthropathy, who has responded dramatically to oral cyclosporin. He presented 8 years ago with low-back pain and rupioid putlar lesions on the feet. Reiter's disease was excluded. His skin and joints have gradually deteriorated with frequent exacerbations, necessitating long periods in hospital. He had not responded to methotrexate, etretinate, azurone, or photochemotherapy (PUVA), and analogues and non-steroidal anti-inflammatory drugs did not help his arthritis. In 1982, when bexonorprofen was prescribed, erthyema multiforme developed.

By 1984, he was immobilised by spinal pain and he had clinical and radiological characteristics of ankylosing spondylitis. Despite large doses of analogues, he needed help to rise from a chair. and most days he was unable to walk the 15 m from his hospital bed to the bathroom. He was given radiotherapy to his spine (150 cGy in ten fractions) with only slight improvement. Besides the spondylitis, he had bilateral knee effusions with synovitis and active arthritis of the left first metatarsophalangeal joint, left wrist, ankle, elbow, and shoulder joints. Prednisolone 30 mg daily and local steroid injections failed to control his symptoms. He was effectively chairbound, losing weight, and in continuous agonising pain. 75% of his total body area was covered in active psoriasis with acral pustulation, and there was hyperkeratosis of the palms and soles.

On July 13, 1984, whilst still taking prednisolone 30 mg, he was put on cyclosporin 5 mg/kg daily (300 mg once daily); after four weeks the dose was increased to 6 mg/kg (200 mg twice daily). At 7 days there was a noticeable improvement and at 10 days there was significant clearing of the skin lesions. At 75 days, his skin was clear apart from slight scaling on the soles. His arthritis and synovitis began to improve after 6 weeks and now, although he is restricted by residual destructive arthropathy, his pain is considerably diminished and he can now rise unaided from a chair and walk freely.