League of Dermatological Societies and its Committee on Nomenclature.[9]

Johnny A. Malak, MD
Beirut, Lebanon

Abdul-Ghani Kibbi, MD
Department of Dermatology
Faculty of Medicine
American University of Beirut
PO Box 113-6044
Beirut, Lebanon

1. Jackson R. On a clear day you can see forever. *Arch Dermatol.* 1991;127:1151-1153.
2. Jackson R. Morphology revisited. *Int J Dermatol.* 1993;32:77-81.
3. Jackson R. The importance of being visually literate: observations on the art and science of making a morphological diagnosis in dematology. *Arch Dermatol.* 1975;111:632-636.
4. Jackson R. Definitions in dermatology: a dissertation on some of the terms used to describe the living gross pathology of human skin. *Clin Exp Dermatol.* 1978;3:241-247.
5. Jackson R. Historical outline of attempts to classify skin diseases. *CMAJ.* 1977; 116:1165-1168.
6. Williams CM. The tyranny of words. *Arch Dermatol Syphilol.* 1935;32:545-550.
7. Bernhardt M. Archives a century ago: selections. *Arch Dermatol.* 1999;135: 254, 297.
8. Gibbs RC. Dermatoses of the feet. In: Gibbs RC, ed. *Differential Diagnosis in Dermatology: A Color Atlas of Dermatological Conditions Presented by Body Site.* Oyster Bay, NY: DM Publishing; 1997:124.
9. Winkelmann RK, the International League of Dermatological Societies–Committee on Nomenclature. Glossary of basic dermatology lesions. *Acta Dermatol Venereol (Suppl).* 1987;130:1-16.

Evaluation of Therapeutic Success of Hyperhidrosis Therapy

We read with interest the article by Karamfilov et al[1] suggesting lower relapse rates of hyperhidrosis after high-dose botulinum toxin type A injections (BOTOX; Allergan Inc, Irvine, Calif; hereinafter, generically, botulinum toxin A).[1] Various protocols for treating hyperhidrosis with botulinum toxin A have been issued empirically without controlled comparison of doses, dilutions, number of injections, or pharmaceutical products. Thus, any attempt to provide evidence-based information on how to optimize botulinum toxin A treatment should be welcomed. For this purpose, however, stringent study designs, accurate measurements of sweating, and uniform follow-up schedules are indispensable. Unfortunately, Karamfilov et al[1] did not implement a control group receiving low-dose botulinum toxin A, which could have been easily provided by a left-vs-right comparison, with each patient being his own control.

Also, the iodine-starch test and planometry, which are helpful to visualize the active hyperhidrotic area, are not pertinent for exact quantification of sweating. In fact, positive findings on the iodine-starch test easily occur in any healthy individual. It is, however, the rate of sweating (amount per minute) that makes a person hyperhidrotic, and this can accurately be determined by gravimetry using blotting paper, a high precision scale, and a stopwatch.[2] In 156 patients recently screened for severe axillary hyperhidrosis, the mean ± SD active area as visualized by the iodine-starch test was 48.5 ± 4.4 cm^2, ranging from 14.2 to 66.5 cm^2, which showed no correlation to actual sweat rates measured by gravimetry (52-858 mg/min). The fact that gravimetric values may vary considerably does not discredit this method but rather demonstrates the dynamics of eccrine glands in hyperhidrotics. After botulinum toxin A treatment, gravimetric sweat rates have been shown to be consistently low.[2,3]

Follow-up as reported by Karamfilov et al[1] ranged from 5 to 15 months, but it remained unclear at what intervals patients were observed—if there was any regular follow-up schedule at all. Waiting for the patient to ask for subsequent treatment is definitely too volatile a parameter for a clinical study, especially when trying to establish measurable benefits compared with already existing protocols. Finally, but not of least importance, the safety of high-dose botulinum toxin A as proclaimed by Karamfilov et al[1] is questionable; the authors failed to mention that the risk of antibody induction rises not only with treatment frequency but also particularly with higher doses.[4]

Marc Heckmann, MD
Klinik für Dermatologie und Allergologie
Frauenlobstr 9-11
80337 Munich, Germany
Martin Schaller, MD
Susanne Breit, MD
Gerd Plewig, MD
Munich

1. Karamfilov T, Konrad H, Karte K, et al. Lower relapse rate of botulinum toxin A therapy for axillary hyperhidrosis by dose increase. *Arch Dermatol.* 2000; 136:487-490.
2. Heckmann M, Breit S, Ceballos BA, et al. Side-controlled intradermal injection of botulinum toxin A in recalcitrant axillary hyperhidrosis. *J Am Acad Dermatol.* 1999;41:987-990.
3. Naumann M, Hofmann U, Bergmann I, et al. Focal hyperhidrosis: effective treatment with intracutaneous botulinum toxin. *Arch Dermatol.* 1998;134: 301-304.
4. Jankovic J, Schwartz K. Response and immunoresistance to botulinum toxin injections. *Neurology.* 1995;45:1743-1746.

The Wheal: To Be or Not to Be

Sad to say, until a dictionary of dermatology equivalent to the Oxford English Dictionary *comes into being, dermatology will forever be a twiglike imposter, rather than an authentic branch of knowledge.*

A. Bernard Ackerman, MD

It is astonishing that the current significantly different meanings of the term *cutaneous elementary lesions* have received so little attention in dermatology journals. But it is precisely for this reason that the renewed controversy regarding basic dermatological lesions reflected in the ARCHIVES holds great interest.[1-4] The suggested elimination of *wheal* "from the list of basic terms"[4] is worthy of comment. In our opinion, there are also reasons favoring its preservation on such a list. Dermatologists have traditionally used a specific term to describe lesions of urticaria except in French dermatology. The analysis of such a tradition may contribute to a better understanding of this controversy.[5]

English Tradition. *Wheal* is an Anglo-Saxon word. Robert Willan and Thomas Bateman turned this into a spe-