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Conflicts of interest: none declared.

Topical glycopyrrolate should not be overlooked in treatment of focal hyperhidrosis

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SIR, The recent review article by Lowe *et al.*[1] on the place of botulinum toxin type A in the treatment of focal hyperhidrosis omits the topical antimuscarinic agent, glycopyrronium bromide. Topical glycopyrrolate (0·5–4% cream, solution or pads) is indicated mainly for the head and neck[2,3] and various types of gustatory sweating (compensatory,[4] diabetic[5] and Frey's)[6] and, in our experience, is effective and well tolerated. EP and USP grade glycopyrrolate powder can be imported into the U.K. and the desired formulation prepared by 'Special Order Manufacturers' (SOMs). The cream formulation should use an acidic base, e.g. Unguentum M, to reduce drug hydrolysis and extend stability; a 3-month expiry is given by some SOMs. The solution, on the other hand, has a shorter expiry, of 1 month, if pH-stabilized and refrigerated.

Glycopyrrolate may be used twice daily, but it is more usually applied at night. Care should be taken to avoid the nose, mouth, and particularly the eyes, where an inadvertent splash can cause failure to accommodate. Patients often experience a dry mouth and throat, and should be warned about that also. We advise not to wash treated skin for 3–4 h after application, and to store the drug in a cool place. If local prescribing authorities do not allow for provision of glycopyrrolate, it may be obtained by mail from Canada (at http://www.pharmacy.ca).

We would also add that the cost of oral glycopyrrolate to date has been very high, at £250 for 100 2-mg tablets, making it difficult to fund for many patients. We have recently found that Nova Laboratories (Leicester, U.K.; tel. 0116 223 0100) not only make up the cream and solution at varying concentrations at an affordable cost, but also make oral glycopyrrolate solution. Their oral solution, 100 mL @ 1 mg mL^{-1}, costs £33 + VAT when ordering two bottles, or £45 + VAT for one; it provides a convenient and affordable source of oral glycopyrrolate.

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No evidence for therapeutic effect of topical ciclosporin in oral lichen planus

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SIR, Conrotto *et al.*[1] make a case for topical ciclosporin in oral lichen planus by stating a comparable symptomatic efficacy and subsequent slower relapse after finishing ciclosporin treatment. On this basis they justify topical ciclosporin as a second-line therapy.

However, by not including a placebo group, their study fails to show whether the topical ciclosporin preparation would be more effective than applying the base hydroxyethyl cellulose gel after each meal, together with the chlorhexidine mouthwash three times daily, and daily miconazole gel given to all subjects. Indeed, it is quite conceivable that the very modest symptomatic improvement in the ciclosporin group (four with no symptoms, 13 with partial response and three with no response over 2 months) was all due to the base and a placebo effect, and not to the active ingredient. The fact that no statistical difference was found between symptoms with the two treatments merely reflects the small size of the study and does not mean comparable efficacy.

The comparison of relapse in clinical response compared with the clobetasol group is flawed as the clobetasol group had a significantly better clinical response to treatment than the ciclosporin group. It is therefore to be expected that more patients would subsequently deteriorate after the treatment period in the more improved clobetasol group than in the ciclosporin group. This statistical relapse difference may merely