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A clinicoepidemiological study of polymorphic light eruption
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A clinico-epidemiological study of PLE was done for a period of one year to include 220 cases of PLE of skin type between IV and VI. The manifestation of PLE was most common in housewives on sun exposed areas. Most of the patients of PLE presented with mild symptoms and rash around neck, lower forearms and arms which was aggravated on exposure to sunlight. PLE was more prevalent in the months of March and September and the disease was recurrent in 31.36% of cases.

Comparative study of efficacy and safety of hydroxychloroquine and chloroquine in polymorphic light eruption: A randomized, double-blind, multicentric study
Anil Pareek, Uday Khopkar, S. Sacchidanand, Nitin Chandurkar, Geeta S. Naik ...................................................... 18

In a double-blind randomized, comparative multicentric study evaluating efficacy of antimalarials in polymorphic light eruption, a total of 117 patients of PLE were randomized to receive hydroxychloroquine and chloroquine tablets for a period of 2 months (initial twice daily dose was reduced to once daily after 1 month). A significant reduction in severity scores for burning, itching, and erythema was observed in patients treated with hydroxychloroquine as compared to chloroquine. Hydroxychloroquine was found to be a safe antimalarial in the dosage studied with lesser risk of ocular toxicity.
Many faces of cutaneous leishmaniasis
Arfan Ul Bari, Simeen Ber Rahman

Symptomatic cutaneous leishmaniasis is diverse in its presentation and outcome in a tropical country like Pakistan where the disease is endemic. The study describes the clinical profile and atypical presentations in 41 cases among 718 patients of cutaneous leishmaniasis. Extremity was the most common site of involvement and lupoid cutaneous leishmaniasis was the most common atypical form observed. Authors suggest that clustering of atypical cases in a geographically restricted region could possibly be due to emergence of a new parasite strain.

Forehead plaque: A cutaneous marker of CNS involvement in tuberous sclerosis
G. Raghu Rama Rao, P. V. Krishna Rao, K. V. T. Gopal, Y. Hari Kishan Kumar, B. V. Ramachandra

In a retrospective study of 15 patients of tuberous sclerosis, eight patients had central nervous system involvement. Among these 8 cases, 7 cases had forehead plaque. This small study suggests that presence of forehead plaque is significantly associated with CNS involvement.

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Ligand-binding prediction for ErbB2, a key molecule in the pathogenesis of leprosy
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**INSTRUCTIONS FOR AUTHORS**

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Camisa disease: A rare variant of Vohwinkel’s syndrome

Sir,

Vohwinkel’s syndrome is a rare, dominantly inherited keratoderma of palms and soles with a characteristic honeycomb appearance, linear and/or starfish keratoses on the extensor surfaces of the elbows, knees, knuckles and hands with flexion contractures and constricting bands (pseudoainhum) of digits resulting in autoamputation.[1,2]

We report a case of Camisa disease, a rare variant of Vohwinkel’s syndrome.

A 3-year-old female child born of 2nd degree consanguineous marriage presented with hyperkeratosis of the palms and soles, linear hyperkeratotic plaques over dorsa of hands with loss of left great toe, of 1-year duration [Figure 1]. Constricting fibrous bands were seen over the right great toe and right 5th toe [Figure 2]. Generalized ichthyosis was present, being more prominent over extremities [Figures 1-2]. Ridging and onychodystrophy was seen in toe nails though hair growth was normal.

Her audiogram, eyes and dental examination were normal. There was no delay in developmental milestones. Hematological and biochemical investigations were within normal limits and peripheral smear showed microcytic hypochromic anemia with mild eosinophilia. Blood serological investigations (HIV and VDRL) were normal. Abdominal scan showed hepatomegaly. Skin biopsy revealed hyperkeratosis, focal parakeratosis, acanthosis, elongation of rete ridges and sparse dermal lymphocytic infiltrate with normal appendages.

Camisa disease is a rare variant of Vohwinkel’s syndrome associated with generalized ichthyosis and without deafness.[1,2] On the basis of recent molecular studies, it is now clear that Vohwinkel’s syndrome associated with ichthyosis is caused by mutations in loricrin gene.[3-5] However, a variant of Vohwinkel’s syndrome which had all the classical clinical features of Vohwinkel’s syndrome but lacking atypical associations like ichthyosis and sensorineural deafness with negative gene mapping for loricrin mutation has been reported recently.[6]

Along with the features of Vohwinkel’s syndrome, our patient had generalized ichthyosis, which is similar to the previous case reports of Camisa variant of Vohwinkel’s syndrome.[1,4] The other clinical variant of Vohwinkel’s syndrome is associated with deafness but no ichthyosis.[3] However, audiogram
revealed no hearing loss in our patient. Histologically the skin lesion showed hyperkeratosis, focal parakeratosis, acanthosis, elongation of rete ridges and sparse dermal lymphocytic infiltrate with normal appendages, which were consistent to earlier case report of an ichthyotic (or Camisa) variant of Vohwinkel's syndrome. Thus our case represents a rare variant of Vohwinkel's syndrome, termed as Camisa disease.

**REFERENCES**


**Fixed drug eruption due to cross reaction between two azoles used for different indications**

Sir,

It is well known that an eruption caused by one drug can be reactivated by another chemically related drug. Usually, these chemically related drugs belong to a single class of therapeutic agents, e.g., antibiotics or anticonvulsants. Such patients are usually advised to avoid the causative drug and chemically similar drugs used for the same indication. However, it is unusual for cross reactions to chemically related drugs to occur across therapeutic categories.

A 27-year-old gynecologist noticed six itchy, oval-to-irregular, erythematous, edematous, hyperpigmented plaques and macules on the face, forearms, fingers, neck and thigh that developed within 1 h of intake of a tablet of fluconazole 150 mg. The macules varied in size from 0.5 to 2 cm. A plaque on the left preauricular region showed blistering. She was treated with clobetasol propionate 0.05% twice daily; and hydroxyzine, 25 mg orally twice daily, with which the lesions subsided leaving behind post-inflammatory hyperpigmentation.

She had had two previous episodes of a similar eruption at the same sites. The first, 4 years ago, following intake of a combination of ciprofloxacin and tinidazole taken for the treatment of diarrhea; and the second, 2 years ago, after taking tablet fluconazole, 150 mg. The second episode was less severe than the first. She had taken ciprofloxacin in the past without any complaint or cutaneous eruption. She had also developed cutaneous wheals and facial swelling after intake of tablet paracetamol and nimesulide, four times in the past. She had episodes of recurrent wheezing after cold and dust exposure, which was relieved with inhaled bronchodilators. There was no family history of atopy.

As cross reactions between chemically related drugs are well known, patients who develop a drug reaction are advised to avoid the causative drug and other drugs prescribed for the same indication, e.g. sulfonamides, cephalosporins and penicillins and the aromatic anticonvulsants, among others. This advice is usually phrased thus: ‘When taking antibiotics (or anticonvulsants or painkillers), avoid this drug and related drugs.’ Our patient’s case represented an uncommon situation, where the cross-reacting drugs were administered for quite different indications: vaginal candidiasis and intestinal amebiasis. Such cross reaction among agents of different therapeutic classes has also been described among the sulfonamide group of drugs.11

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