EDITORIAL

Management of autoimmune urticaria
Arun C. Inamadar, Aparna Palit .......................................................... 89

VIEWPOINT

Cosmetic dermatology versus cosmetology: A misnomer in need of urgent correction
Shyam B. Verma, Zoe D. Draelos ........................................................... 92

REVIEW ARTICLE

Psoriasiform dermatoses
Virendra N. Sehgal, Sunil Dogra, Govind Srivastava, Ashok K. Aggarwal ...... 94

ORIGINAL ARTICLES

A study of allergen-specific IgE antibodies in Indian patients of atopic dermatitis
V. K. Somani ......................................................................................... 100

Chronic idiopathic urticaria: Comparison of clinical features with positive autologous serum skin test
George Mamatha, C. Balachandran, Prabhu Smitha ................................ 105

Autologous serum therapy in chronic urticaria: Old wine in a new bottle
A. K. Bajaj, Abir Saraswat, Amitabh Upadhyay, Rajetha Damisetty, Sandipan Dhar .............................................................. 109

Use of patch testing for identifying allergen causing chronic urticaria
Ashimav Deb Sharma ........................................................................... 114

Vitiligoid lichen sclerosus: A reappraisal
Venkat Ratnam Attili, Sasi Kiran Attili ................................................. 118
BRIEF REPORTS

Activated charcoal and baking soda to reduce odor associated with extensive blistering disorders
Arun Chakravarthi, C. R. Srinivas, Anil C. Mathew

Nevus of Ota: A series of 15 cases
Shanmuga Sekar, Maria Kuruvila, Harsha S. Pai

Premature ovarian failure due to cyclophosphamide: A report of four cases in dermatology practice
Vikrant A. Saoji

CASE REPORTS

Hand, foot and mouth disease in Nagpur
Vikrant A. Saoji

Non-familial multiple keratoacanthomas in a 70 year-old long-term non-progressor HIV-seropositive man
Hemanta Kumar Kar, Sunil T. Sabhnani, R. K. Gautam, P. K. Sharma, Kalpana Solanki, Meenakshi Bhardwaj

Late onset isotretinoin resistant acne conglobata in a patient with acromegaly
Kapil Jain, V. K. Jain, Kamal Aggarwal, Anu Bansal

Familial dyskeratotic comedones
M. Sendhil Kumaran, Divya Appachu, Elizabeth Jayaseelan
<table>
<thead>
<tr>
<th>Title</th>
<th>Authors</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal NK/T cell lymphoma presenting as a lethal midline granuloma</td>
<td>Vandana Mehta, C. Balachandran, Sudha Bhat, V. Geetha, Donald Fernandes</td>
<td>145</td>
</tr>
<tr>
<td>Childhood sclerodermatomyositis with generalized morphea</td>
<td>Girishkumar R. Ambade, Rachita S. Dhurat, Nitin Lade, Hemangi R. Jerajani</td>
<td>148</td>
</tr>
<tr>
<td>Subcutaneous panniculitis-like T-cell cutaneous lymphoma</td>
<td>Avninder Singh, Joginder Kumar, Sujala Kapur, V. Ramesh</td>
<td>151</td>
</tr>
<tr>
<td><strong>LETTERS TO EDITOR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using a submersible pump to clean large areas of the body with antiseptics</td>
<td>C. R. Srinivas</td>
<td>154</td>
</tr>
<tr>
<td>Stratum corneum findings as clues to histological diagnosis of pityriasis lichenoides chronica</td>
<td>Rajiv Joshi</td>
<td>156</td>
</tr>
<tr>
<td>Author's reply</td>
<td>S. Pradeep Nair</td>
<td>157</td>
</tr>
<tr>
<td>Omalizumab in severe chronic urticaria</td>
<td>K. V. Godse</td>
<td>157</td>
</tr>
<tr>
<td>Hypothesis: The potential utility of topical eflornithine against cutaneous leishmaniasis</td>
<td>M. R. Namazi</td>
<td>158</td>
</tr>
<tr>
<td>Nodular melanoma in a skin graft site scar</td>
<td>A. Gnaneshwar Rao, Kamal K. Jhamnani, Chandana Konda</td>
<td>159</td>
</tr>
<tr>
<td>Title</td>
<td>Authors</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Palatal involvement in lepromatous leprosy</td>
<td>A. Gnaneshwar Rao, Chandana Konda, Kamal Jhamnani</td>
<td>161</td>
</tr>
<tr>
<td>Unilateral nevoid telangiectasia with no estrogen and progesterone</td>
<td>F. Sule Afsar, Ragip Ortac, Gulden Diniz</td>
<td>163</td>
</tr>
<tr>
<td>Eruptive lichen planus in a child with celiac disease</td>
<td>Dipankar De, Amrinder J. Kanwar</td>
<td>164</td>
</tr>
<tr>
<td>Xerosis and pityriasis alba-like changes associated with zonisamide</td>
<td>Feroze Kaliyadan, Jayasree Manoj, S. Venkitakrishnan</td>
<td>165</td>
</tr>
<tr>
<td>Treatment of actinomycetoma with combination of rifampicin and co-</td>
<td>Rajiv Joshi</td>
<td>166</td>
</tr>
<tr>
<td>trimoxazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author’s reply</td>
<td>M. Ramam, Radhakrishna Bhat, Taru Garg, Vinod K. Sharma, R. Ray, M. K.</td>
<td>168</td>
</tr>
<tr>
<td></td>
<td>Singh, U. Banerjee, C. Rajendran</td>
<td></td>
</tr>
<tr>
<td>Vitiligo, psoriasis and imiquimod: Fitting all into the same pathway</td>
<td>Bell Raj Eapen</td>
<td>169</td>
</tr>
<tr>
<td>Author’s reply</td>
<td>Engin Şenel, Deniz Seçkin</td>
<td>169</td>
</tr>
<tr>
<td>Multiple dermatofibromas on face treated with carbon dioxide laser:</td>
<td>Kabir Sardana, Vijay K. Garg</td>
<td>170</td>
</tr>
<tr>
<td>The importance of laser parameters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author’s reply</td>
<td>D. S. Krupa Shankar, A. Kushalappa, K. S. Uma, Anjay A. Pai</td>
<td>170</td>
</tr>
<tr>
<td>Alopecia areata progressing to totalis/universalis in non-insulin</td>
<td>Virendra N. Sehgal, Sambit N. Bhattacharya, Sonal Sharma, Govind Srivasta,</td>
<td>171</td>
</tr>
<tr>
<td>dependent diabetes mellitus (type II): Failure of dexamethasone-cyclo</td>
<td>Ashok K. Aggarwal</td>
<td></td>
</tr>
<tr>
<td>phosphamide pulse therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subungual exostosis</td>
<td>Kamal Aggarwal, Sanjeev Gupta, Vijay Kumar Jain, Amit Mital, Sunita Gupta</td>
<td>173</td>
</tr>
</tbody>
</table>
The copies of the journal to members of the association are sent by ordinary post. The editorial board, association or publisher will not be responsible for non-receipt of copies. If any of the members wish to receive the copies by registered post or courier, kindly contact the journal's publisher’s office. If a copy returns due to incomplete, incorrect or changed address of a member on two consecutive occasions, the names of such members will be deleted from the mailing list of the journal. Providing complete, correct and up-to-date address is the responsibility of the members. Copies are sent to subscribers and members directly from the publisher’s address; it is illegal to acquire copies from any other source. If a copy is received for personal use as a member of the association/society, one cannot resale or give-away the copy for commercial or library use.

Clinicohistopathological correlation of leprosy
Amrish N. Pandya, Hemali J. Tailor ................................................................. 174

RESIDENT’S PAGE

Dermatographism
Dipti Bhute, Bhavna Doshi, Sushil Pande, Sunanda Mahajan, Vidya Kharkar ................................................................. 177

FOCUS

Mycophenolate mofetil
Amar Surjushe, D. G. Saple ........................................................................... 180

QUIZ

Multiple papules on the vulva
G. Ragh Rama Rao, R. Radha Rani, A. Amareswar, P. V. Krishnam
Raju, P. Raja Kumari, Y. Hari Kishan Kumar .................................................. 185

NHJDM

Oral isotretinoin is as effective as a combination of oral isotretinoin and topical anti-acne agents in nodulocystic acne
Rajeev Dhir, Neetu P. Gehi, Reetu Agarwal, Yuvraj E. More ............................ 187

Net Case
Cutaneous diphtheria masquerading as a sexually transmitted disease
T. P. Vetrichewvel, Gajanan A. Pise, Kishan Kumar Agrawal,
Devinder Mohan Thappa .................................................................................. 187

Net Letters
Patch test in Behcet’s disease
Ülker Gül, Müzeyyen Gönül, Seray Külçü Çakmak, Arzu Kuç ................................ 187

Cerebriform elephantiasis of the vulva following tuberculous lymphadenitis
Surajit Nayak, Basanti Achariya, Basanti Devi, Satyadarshi Pattnaik,
Manoj Kumar Patra ............................................................................................ 188

Net Quiz
Vesicles on the tongue
Saurabh Agarwal, Krishna Gopal, Binay Kumar .................................................. 188
Letters to the Editor

chemotherapy against leishmaniasis. The trypanothione pathway combines two metabolic pathways: the glutathione and the polyamine biosynthetic pathways, to produce trypanothione, a glutathione-spermidine conjugate.[1]

The levels of trypanothione are increased in the Leishmania parasite selected for resistance to the heavy metal, arsenic. The levels of putrescine and spermidine were increased in resistant mutants. This increase is mediated by overexpression of ornithine decarboxylase, the rate-limiting enzyme in polyamine biosynthesis.[2] Fluorinated analogues of L-ornithine are powerful inhibitors of ornithine decarboxylase and inhibit the cell growth of L. infantum promastigotes.[3]

Eflornithine was originally used orally in the treatment of childhood hyperactivity.[4] It was used as an anti-cancer drug in 1970[5] and was later used intravenously in the treatment of African sleeping sickness.[5,6] Interestingly, hair loss was observed as an adverse effect of this treatment.[5,7] Eflornithine hydrochloride cream (13.9%) is the first topical preparation approved by the FDA in August 2000 for the reduction of facial hirsutism in women.[5] It is a potent inhibitor of ornithine decarboxylase. A topical formulation of this agent has been used for treatment of hirsute women as inhibition of ornithine decarboxylase delays the initiation of anagen and keeps hair in telogen. Therefore, eflornithine does not remove the excess hair but it causes slowing of excessive hair growth.

Given the important role of ornithine decarboxylase in the trypanothione biosynthetic pathway, eflornithine could prove to be effective against leishmaniasis. Combining this agent with glucantime could potentiate the therapeutic response of the latter and break the resistance of the resistant strains against it. Clinical studies on this subject are warranted.

M. R. Namazi

Department of Dermatology, Shiraz University of Medical sciences, Shiraz, Iran

Address for correspondence: Dr. M. R. Namazi, Dermatology Department, Faghihi Hospital, Zand Street, Shiraz, Iran. E-mail: namazi_mr@yahoo.com

References


Nodular melanoma in a skin graft site scar

Sir,

Nodular melanoma is the second most common subtype of cutaneous melanomas with a frequency of 15-30%.[1] Most frequently it presents in midlife with a median age at presentation of 53 years, it is more common in males than in females. Recognition of nodular melanomas can be problematic as they lack many of the conventional clinical features.

A 47 year-old man was referred to the Dermatology Department with complaints of a nonhealing ulcer over the right thigh and popliteal fossa prevalent since the last two years and also, nodules over the right lower limb extending up to the ankles observed for the last eight months. The patient was apparently asymptomatic two years before when he met with an accident leading to a nonhealing ulcer over the right thigh. There was no history of any burn injury. The ulcer was treated with skin grafting from the left thigh. The graft site healed well at that time. Gradually over the span of a few months, the patient developed small swellings over the scar of the grafted site. This was followed by ulceration and rapid growth of a fungating mass extending up to the popliteal fossa. This was associated with a serosanguineous discharge. Over the next year, the patient started developing skin-colored nodules over the right lower limb below the growth extending up to the dorsum of the foot. The growth was painless and asymptomatic to start with but

Sir,

Nodular melanoma is the second most common subtype of cutaneous melanomas with a frequency of 15-30%.[1] Most frequently it presents in midlife with a median age at presentation of 53 years, it is more common in males than in females. Recognition of nodular melanomas can be problematic as they lack many of the conventional clinical features.

A 47 year-old man was referred to the Dermatology Department with complaints of a nonhealing ulcer over the right thigh and popliteal fossa prevalent since the last two years and also, nodules over the right lower limb extending up to the ankles observed for the last eight months. The patient was apparently asymptomatic two years before when he met with an accident leading to a nonhealing ulcer over the right thigh. There was no history of any burn injury. The ulcer was treated with skin grafting from the left thigh. The graft site healed well at that time. Gradually over the span of a few months, the patient developed small swellings over the scar of the grafted site. This was followed by ulceration and rapid growth of a fungating mass extending up to the popliteal fossa. This was associated with a serosanguineous discharge. Over the next year, the patient started developing skin-colored nodules over the right lower limb below the growth extending up to the dorsum of the foot. The growth was painless and asymptomatic to start with but
Letters to the Editor

Figure 1: Back of right knee showing ulcerative growth

Figure 2: Diffuse dense infiltration by neoplastic cells (H and E, ×100)

Figure 3: Pleomorphic cells with prominent eosinophilic nucleoli (H and E, ×400)

as it grew, it caused pain and limitation of mobility due to pressure effects. The patient was otherwise well with no previous significant medical history. He was addicted to smoking and occasionally consumed alcohol. The general examination was unremarkable except for edema over the right foot. Cutaneous examination revealed a fungating mass over the right popliteal fossa with interspersed areas of necrosis and a healed ulcer over the lateral aspect of the thigh [Figure 1]. Skin-colored to hyperpigmented nodules distributed over the entire right leg were firm to bony hard in consistency. Regional inguinal lymphadenopathy was present which was bony hard in consistency. With these features, a clinical diagnosis of Marjolin’s ulcer was made. Differential diagnoses that were considered included pigmented basal cell carcinoma, eccrine poroma, blue nevus and pyogenic granuloma. Skin biopsy was taken from the edge of the fungating mass and also from the nodule. Histopathological examination revealed extensive areas of necrosis, hemorrhage and tumor tissue with pleomorphic cells and pleomorphic nuclei with prominent eosinophilic nucleoli. Both intra- and extracellular melanin pigment was seen [Figures 2-3]. The specimen revealed mitotic figures and also tumor giant cells. HMB-45 studies were positive. Based on these histopathological findings, a diagnosis of nodular melanoma was made.

Malignant melanoma arising from burn scars are rare with only 27 cases being reported so far.[2] Malignant melanomas arising in skin grafts are even more rare with only two case reports.[3] Hall et al. reported a case who developed melanoma within a skin graft donor site and an invasive melanoma within the recipient graft site.[4] Carcinoma developing in burn scars is overwhelmingly of the squamous cell type. In fact, almost 2% of all squamous cell carcinomas develop in old burn scars.[5] According to recent literature, most of the melanomas have been reported in burn scars with an incidence of about 6% of all burn scar neoplasms. While reviewing 412 burn scar neoplasms, Kowal-Vern et al. reported a mean latency interval of 31 years.[6] The case under study had a latency interval of two years, which is short. Multiple malignant melanomas may develop in different burn scar areas. Hwang et al. described a case who developed malignant melanomas at two different sites of burn scars[7] Spring et al. have reported a case where malignant melanoma developed at the site of excision of a squamous cell carcinoma.[8] Gamatsi et al. have reported a case of malignant melanoma which developed in a burn injury treated with a skin graft. While analyzing the cause of malignant melanoma in grafted skin, the authors opined that the malignant melanoma might have been transferred to the recipient site along with the skin graft.[9] In view of varied clinical presentation of nodular melanoma, a high index of suspicion is needed in all cases of injuries and burns treated with skin grafts. Such cases need to be followed up periodically so that an early diagnosis can be made and
treated promptly. We have presented this uncommon case to emphasize the importance of follow-up in cases of injury and burns treated with skin grafts.

A. Gnaneshwar Rao, Kamal K. Jhamnani, Chandana Konda
Department of Dermatology, Gandhi Medical College and Hospital, Musheerabad, Hyderabad, India

REFERENCES