EDITIORIAL

Management of autoimmune urticaria
Arun C. Inamadar, Aparna Palit

VIEWPOINT

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

REVIEW ARTICLE

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

ORIGINAL ARTICLES

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

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

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

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

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

Activated charcoal and baking soda to reduce odor associated with extensive blistering disorders
Arun Chakravarthi, C. R. Srinivas, Anil C. Mathew ................................................................. 122

Nevus of Ota: A series of 15 cases
Shanmuga Sekar, Maria Kuruvila, Harsha S. Pai ................................................................. 125

Premature ovarian failure due to cyclophosphamide: A report of four cases in dermatology practice
Vikrant A. Saoji ......................................................................................................................... 128

CASE REPORTS

Hand, foot and mouth disease in Nagpur
Vikrant A. Saoji ......................................................................................................................... 133

Non-familial multiple keratoacanthomas in a 70 year-old long-term non-progressor HIV-seropositive man

Late onset isotretinoin resistant acne conglobata in a patient with acromegaly
Kapil Jain, V. K. Jain, Kamal Aggarwal, Anu Bansal ............................................................... 139

Familial dyskeratotic comedones
M. Sendhil Kumaran, Divya Appachu, Elizabeth Jayaseelan ..................................................... 142
Nasal NK/T cell lymphoma presenting as a lethal midline granuloma
Vandana Mehta, C. Balachandran, Sudha Bhat, V. Geetha, Donald Fernandes ..................................................... 145

Childhood sclerodermatomyositis with generalized morphea
Girishkumar R. Ambade, Rachita S. Dhurat, Nitin Lade, Hemangi R. Jerajani...................................................... 148

Subcutaneous panniculitis-like T-cell cutaneous lymphoma
Avninder Singh, Joginder Kumar, Sujala Kapur, V. Ramesh..................................................................................... 151

LETTERS TO EDITOR

Using a submersible pump to clean large areas of the body with antiseptics
C. R. Srinivas................................................................................................................................................................. 154

Peutz-Jeghers syndrome with prominent palmoplantar pigmentation

Stratum corneum findings as clues to histological diagnosis of pityriasis lichenoides chronica
Rajiv Joshi ..................................................................................................................................................................... 156

Author’s reply
S. Pradeep Nair ............................................................................................................................................................. 157

Omalizumab in severe chronic urticaria
K. V. Godse ..................................................................................................................................................................... 157

Hypothesis: The potential utility of topical eflornithine against cutaneous leishmaniasis
M. R. Namazi ................................................................................................................................................................ 158

Nodular melanoma in a skin graft site scar
A. Gnaneshwar Rao, Kamal K. Jhamnani, Chandana Konda ................................................................................... 159
Palatal involvement in lepromatous leprosy
A. Gnaneshwar Rao, Chandana Konda, Kamal Jhamnani ................................................................. 161

Unilateral nevoid telangiectasia with no estrogen and progesterone receptors in a pediatric patient
F. Sule Afsar, Ragip Ortac, Gulden Diniz .......................................................................................... 163

Eruptive lichen planus in a child with celiac disease
Dipankar De, Amrinder J. Kanwar ........................................................................................................ 164

Xerosis and pityriasis alba-like changes associated with zonisamide
Feroze Kaliyadan, Jayasree Manoj, S. Venkitakrishnan ........................................................................ 165

Treatment of actinomycetoma with combination of rifampicin and co-trimoxazole
Rajiv Joshi ................................................................................................................................................ 166

Author’s reply

Vitiligo, psoriasis and imiquimod: Fitting all into the same pathway
Bell Raj Eapen ........................................................................................................................................ 169

Author’s reply
Engin Şenel, Deniz Seçkin ....................................................................................................................... 169

Multiple dermatofibromas on face treated with carbon dioxide laser: The importance of laser parameters
Kabir Sardana, Vijay K. Garg .................................................................................................................. 170

Author’s reply

Alopecia areata progressing to totalis/universalis in non-insulin dependent diabetes mellitus (type II): Failure of dexamethasone-cyclophosphamide pulse therapy
Virendra N. Sehgal, Sambit N. Bhattacharya, Sonal Sharma, Govind Srivastava, Ashok K. Aggarwal ................................................................................................................................. 171

Subungual exostosis
Kamal Aggarwal, Sanjeev Gupta, Vijay Kumar Jain, Amit Mital, Sunita Gupta ........................................... 173
Clinicohistopathological correlation of leprosy
Amrish N. Pandya, Hemali J. Tailor ................................................................. 174

RESIDENT’S PAGE
Dermatographism
Dipti Bhute, Bhavana Doshi, Sushil Pande, Sunanda Mahajan, Vidya Kharkar ................................................................. 177

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

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

E-IJDVL
Net Study
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. Vetrichevvel, 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 Kılç ................................................................. 187

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

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

Sir,
Leprosy is one of the major public health problems of the developing countries. The principle of reducing the load of infection in society, to break the chain of infection, is the cornerstone of leprosy control work today. Clinical judgment and skin smear examination is required for early diagnosis and adequate treatment to make the patient noninfectious. But in some early and borderline cases of leprosy, it is difficult to label only on clinical basis. So, histopathological examination is a must for confirmation of diagnosis in doubtful cases of leprosy. Moreover, correct labeling of paucibacillary and multibacillary cases is a prerequisite. No multibacillary case should be treated as paucibacillary case. So, clinicohistopathological correlation of leprosy cases assumes a pivotal role for early diagnosis and for proper labeling of a case.
Fifty skin biopsies, of clinically suspected leprosy cases, were stained by Haematoxylin and Eosin and Ziehl Neelsen stain methods. The Ridley and Jopling classification was followed in both clinical and histopathological diagnoses. We also included indeterminate and histoid types of leprosy for analysis. The data pertaining to age, sex, clinical and histopathological classification of the type of leprosy were collected and analyzed. In analyzing the histopathology of a lesion, special attention was given to the following features, viz., invasion of the epidermis with or without erosion, involvement of the sub-epidermal zone, character and extent of granuloma, density of lymphocytic infiltrate, epithelioid cells and other cellular elements, nerve involvement and the presence of M. leprae.

Results of our study are mentioned in Table 1.

When M. leprae enters a person with sufficient cell-mediated immunity (CMI) against it, the bacilli will be destroyed. If the CMI is slightly impaired, some bacilli will multiply and a lesion will develop. Depending upon the degree of the immunity, more apparent clinical and histopathological features of the various types of leprosy may gradually develop. On histopathological study, the type of the granuloma cell serves to provide the spectrum of leprosy in two, with epithelioid cells extending from TT to BB and macrophages occurring in BL and LL.

Lymphocytes are the most numerous of all in BL, a few in BB and most scanty in LL. Erosion of epidermis by granuloma is often a valuable sign for the identification of TT. Infiltration of the subepidermal zone is almost invariable in TT, but inconstant in BT. This zone is almost clear, unless compressed by an expanding granuloma, in BB, BL and LL. In the present study, a complete parity between clinical type and histological type was noted in 58% cases [Table 1].

Ridley and Jopling in their study of 82 cases found complete agreement between clinical and histological types in 56 patients (68.3%).[2] Kar et al. in their study observed total parity in 70%. They also observed highest parity in stable poles, i.e. TT (87.5%) and LL (71.4%), followed by BL (81.2%), BT (60.9%), BB (54.5%) and BL (53.8%).[3] Kalla et al. in a study of 736 patients observed highest parity in LL and TT group (76.7% and 75.6%), respectively, followed by BT (44.2%), BL (43.7%) and BB (37.0%).[4] Jerath and Desai in a study of 130 cases found complete agreement in 89 cases (68.5%). The figures for individual groups were TT (74.5%), BT (64.7%), BB (53.8%) and BL (28.5%), LL (61.5%) and indeterminate leprosy (88.8%).[5] Considering the data of present study and other comparative studies, we can say that maximum disparity is seen in borderline cases. Parity in the polar group is maximum, because they are stable and showed a fixed histopathology, while borderline and indeterminate groups may have different histopathology in different site and lesion.

The clinicopathological picture is determined by the equilibrium between the agent and the host resistance. Skin has different pathophysiological subunits wherein there is some local modulation of the central host response as a result of which there are different grades of resistance and hence different clinicopathological responses in different areas. We conclude from our study that histopathological examination should be carried out in all cases of leprosy to arrive at a definite diagnosis of leprosy and to classify the type of the disease.

**Table 1: Clinical and histopathological correlation**

<table>
<thead>
<tr>
<th>Clinical types</th>
<th>No. of cases</th>
<th>Histopathological diagnosis</th>
<th>% of parity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>histoid</td>
<td>TT</td>
<td>BT</td>
</tr>
<tr>
<td>TT</td>
<td>3</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>BT</td>
<td>15</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BB</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BL</td>
<td>11</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>LL</td>
<td>6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>IL</td>
<td>8</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Histoid</td>
<td>5</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

**Address for correspondence:** Dr. Amrish N. Pandya, 702/B, Amrutdhara Apartments, Opposite St. Xavier’s School, Ghod Dod Road, Surat - 395 001, India.
E-mail: dr.amrish21@yahoo.com

**Amrish N. Pandya, Hemali J. Tailor**
Department of Pathology, Government Medical College, Surat, India
REFERENCES