two weeks failed to show growth of any fungus.

Dermatophyte infection from the inguinal area may extend to the scrotum and uncommonly to the penis, but rarely occurs on the glans or prepuce. In the present case the provisional clinical diagnosis was Candida infection of the prepuce, however a ring-like configuration with central clearing and mild scaling at the border prompted the 10% KOH smear and subsequent culture, which proved the infection to be of T. rubrum.

It is widely accepted that dermatophytes are keratinophilic in nature and they invade their host by enzymatic digestion of the keratin. However, many workers have been unable to demonstrate enzymes produced by dermatophytes with keratin-specific proteinase activity. In vitro, non-keratin substances extracted from keratinized tissues will support the growth of dermatophytes much better than the keratin. This may be true for the present case, since anatomically the glans penis and inner surface of the prepuce are covered with non-keratinized epithelium. Also the uncircumcised preputial surface is continually moist and may accumulate smegma, which is an excellent medium for the growth of pathogens. Tropical climate also plays an important role in the pathogenesis of dermatophytosis of the genitalia. In the present patient, probably all these factors led to dermatophyte infection in a rare site, perhaps from contact with the spouse’s ringworm infection during sexual activity.

There have been some reports of extensive and persistent cases of tinea corporis in which dermal and subcutaneous involvement has been a feature. A few cases of deep dermatophytoses affecting bone, the central nervous system and lymph nodes, have been reported, but no satisfactory explanation for this highly unusual behavior of the dermatophytes is yet available.

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Familial speckled acral hypopigmentation: A new variant of reticulate acropigmentation?

Sir,

Reticulate acropigmentation disorders include reticulate acropigmentation of Kitamura (RAPK), Dowling Degos disease (DDD), acropigmentation of Dohi and dyschromatosis universalis heredetaria (DUH). While RAPK and DDD are characterized by hyperpigmentation, acropigmentation of Dohi and DUH have both hyper and hypopigmentation. Herein we report a case who has hypopigmentation in a speckled fashion on the sides of the dorsa of both the hands and feet.

A girl aged 14 years presented with speckled hypopigmentation on the sides of the dorsa of the hands and feet (Figures 1 and 2). On enquiry she informed that her elder sister and cousin had similar lesions. Unlike other reticulate hypopigmentations they were confined only to the sides rather than the whole dorsa of feet and/or hands. Atrophy or pits on the dorsa and/or palms were absent. The pattern looked speckled due to hypopigmented macules of more or less uniform size (2-4 mm) on a background of normal colored skin.
Letters to Editor

Figure 1: Speckled acral hypopigmentation on the sides of the dorsum of foot (medial aspect)

Figure 2: Similar lesions on the sides of the dorsa of hands (radial aspect)

Figure 3: DOPA staining of the patient’s cells [from skin specimen]
(a) Left panel: control (without DOPA); (b) Right panel: with DOPA.

Biopsy from the hypopigmented area showed marked decrease in melanocytes. Dopa staining was negative (Figure 3). In skin sample of the patient the presence of melanocytes was rare and these very few cells showed negative result with DOPA staining. The most striking feature of this entity is alternate hypo and normal pigmentation in a symmetrical distribution.

In RAPK, multiple, hyperpigmented, irregularly angulated, atrophic macules of 1-5 mm are seen over the dorsa of hands and feet, the sides of the neck, and occasionally on the face in a symmetrical distribution.[1-2] Palmar pits and breaks in an epidermal ridge pattern are characteristic of RAPK.[1] In DDD, dark brown non-atrophic macules of 1-4 mm are present over flexures, inner aspects of thighs, neck and submammary regions in a symmetrical distribution.[4] Other features of DDD are comedo-like, hyperkeratotic, follicular lesions over the face and acneiform pitted scars.[2] A combination of angulated, non-atrophic, dark brown, freckle-like macules and non-atrophic depigmented macules over the dorsa of the hands without any palmar pits are the main features of Dohi.[3] DUH has both hypo and hyperpigmentation and the distribution is generalized including acral areas. Recently, a localized form of DUH has also been reported.[3] RAPK and DDD are characterized by only hyperpigmentation whereas acropigmentation of Dohi and DUH have both hyper and hypopigmentation. The clinical pattern of hypopigmentation, as described in the entity of symmetric acroleukopathy in a family, dealt with an area of depigmentation of the whole of periungual region. But, that was neither reticulated nor speckled in character.[5] In our case the most interesting feature is alternate hypo and normal pigmentation. To the best of our knowledge speckled pattern of acral hypopigmentation has not been reported earlier and probably represents a new variant of reticulate acropigmentation.

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Disseminated papules were seen on the trunk. Oral mucosa, palms and soles were normal. Discoloration and dystrophy were seen on the finger and toenails.

Investigation results revealed hemoglobin of 8.2 gm%; total count of 10,000 cells/cmm with 34% polymorphs, 58% lymphocytes and 8% eosinophils. ESR was 46 mm at one hour. The other investigations like blood sugar, renal and liver function tests were normal.

Histopathologic examination of the nodules under H and E revealed normal epidermis with micro-abscess formation in the dermis. Special stain with Gomori’s methenamine silver (GMS) demonstrated the fungus. The fungus was seen with the characteristic branching at an angle of 45° within thrombi in vessels, which was consistent with aspergillus species (Figure 2). Skin nodule and nail culture in SDA medium grew Aspergillus

Primary cutaneous aspergillosis

Sir,

Aspergillosis is an uncommon opportunistic fungal infection caused by a variety of species of which Aspergillus fumigatus and niger are the common ones.[1] Aspergillus flavus is most commonly associated with primary cutaneous aspergillosis and Aspergillus fumigatus with disseminated disease. Aspergillosis is generally a complication of severe debilitating illnesses and occurs in patients suffering from malignancies, tuberculosis, silicosis and diabetes. It also occurs in patients who are receiving long-term corticosteroids, antibiotics or cytotoxic drugs and in immuno-compromised states.[1] Cutaneous lesions are rare in aspergillosis. Primary cutaneous aspergillosis may present as macules, papules, plaques or hemorrhagic bullae, which may progress into necrotic ulcers that are covered by a heavy black eschar.[2] Voriconazole is a new antifungal agent found to be effective in aspergillosis.[3,4] We report a case of primary cutaneous aspergillosis in a patient on oral corticosteroids.

A 45-year-old farmer, presented with history of multiple painful nodules over the extremities and trunk for two years. The lesions gradually increased in size and new nodules appeared in the last six months prior to admission. The patient had been diagnosed to have chronic dermatitis earlier and was taking oral prednisolone at a dose of 20 mg per day for more than a year prior to the onset of painful nodules. On examination there were multiple large and small tender nodules on the face, limbs and trunk. Over the right hand and foot the nodules measured 6 x 10 cm in size (Figure 1). Infiltrated, erythematous papules were seen on the nose, forehead and cheek. Similar discrete disseminated papules were seen on the trunk. Oral mucosa, palms and soles were normal. Discoloration and dystrophy were seen on the finger and toenails.

Investigation results revealed hemoglobin of 8.2 gm%; total count of 10,000 cells/cmm with 34% polymorphs, 58% lymphocytes and 8% eosinophils. ESR was 46 mm at one hour. The other investigations like blood sugar, renal and liver function tests were normal. Histopathologic examination of the nodules under H and E revealed normal epidermis with micro-abscess formation in the dermis. Special stain with Gomori’s methenamine silver (GMS) demonstrated the fungus. The fungus was seen with the characteristic branching at an angle of 45° within thrombi in vessels, which was consistent with aspergillus species (Figure 2). Skin nodule and nail culture in SDA medium grew Aspergillus

Figure 1: A large nodule on the ring finger

Figure 2: Lumen of blood vessel containing blood clot in which fungal hyphae are embedded (H/E, x400)