(celecoxib and valdecoxib) could possibly cross react with sulfonamides. The sulfonamide-type reactions (erythema multiforme, Stevens Johnson syndrome, toxic epidermal necrolysis (TEN) and maculopapular rash) were found to be twice as common with celecoxib as with rofecoxib. The pathogenesis of these reactions is likely to be the same as for sulfonamide induced reactions – T cell mediated type IV hypersensitivity reaction. However, Shapiro et al in their study on the safety of celecoxib in 28 patients with a history of sulfonamide allergy found cross reactivity between celecoxib and sulfonamides to be low.

The coxibs have generally been found to be safe even in patients allergic to the classic NSAIDs. Sanchez-Borges et al, in their review of cutaneous reactions to selective COX-2 inhibitors, reported that, among patients previously exhibiting urticaria or angioedema triggered by classic NSAIDs, only 1.6% developed urticaria or angioedema to rofecoxib and 11.2% to celecoxib. However, in the present case, the patient had been tolerating various NSAIDs in the past but reacted to a coxib.

As the patient had taken rofecoxib on more than two occasions, with no side effects, it appears that there may not necessarily be cross reactivity between different coxibs.

To conclude, cutaneous adverse reactions to coxibs continue to be reported. Although these drugs are considered safer in individuals sensitive to other NSAIDs, this case suggests that the reverse could also be true.

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Isolated scalp collagenoma mimicking cutis verticis gyrata

Sir,
Cutis verticis gyrata (CVG) is a descriptive term for a condition of the scalp, in which deep furrows and convolutions are seen, that resembles the outer surface of the cerebrum. The etiology is diverse, since different collections of cell types may be responsible for outward convoluted appearance, and range from inflammatory or hamartomatous infiltrations to neoplastic proliferations. Collagenoma or connective tissue nevi of the collagen type are hamartomatous lesions, consisting of proliferation of normal collagen tissue. They can be hereditary or sporadic. The lesions consist of slightly elevated nodules that may be grouped or disseminated. Collagenomas located in the plantar or palmar surface with a cerebriform appearance are rare, and have been reported in Proteus syndrome. Herewith, isolated scalp collagenoma mimicking cutis verticis gyrata is being reported for its rarity and unique localization.

A 35-year-old female presented with asymptomatic, asymmetrically located, solitary, cerebriform skin colored plaque of 18×12 cm over the left temporal scalp since birth [Figure 1]. The plaque had been...
Connective tissue nevi of the hereditary type include dermatofibrosis lenticularis disseminata in the Buschke-Ollendorff syndrome, familial cutaneous collagenoma, and shagreen patches seen in tuberous sclerosis. Connective tissue nevi of acquired type have been classified as eruptive collagenomas, isolated collagenomas, or isolated elastomas, depending on the number of lesions and the predominant dermal fibers present. Familial cutaneous collagenoma is characterized by a symmetrical eruption of collagen-type nodules and plaques occurring predominantly over the upper back in adolescence. Shagreen patches are present in tuberous sclerosis, in association with the classic skin findings of adenoma sebaceum, periungual fibromas, and ash-leaf macules. Plantar collagenomas with cerebriform appearance have been described as one of the major skin findings of Proteus syndrome. However, three cases of isolated plantar collagenoma without associated clinical abnormalities have been reported. In one case of isolated collagenoma, Uitto et al. showed that the increased collagen is of the adult type (Type I) and that a local reduction of collagenase might be the cause of the excess collagen. In contrast to cutis verticis gyrata (CVG) with a diffuse involvement of scalp, isolated collagenoma presents as a localized abnormality. Biopsies from CVG usually show a thickened dermis with possible sebaceous hyperplasia, with or without collagen excess, whereas isolated collagenoma only shows excess of collagen without sebaceous hyperplasia. To the best of our knowledge, we could not find such a report of isolated collagenoma of the scalp presenting as cutis verticis gyrata, in the published literature.

In summary, collagenoma may be a marker for internal disease such as tuberous sclerosis, may occur in familial or eruptive patterns, or may be present in isolation, as in our case. As such, isolated cerebriform scalp collagenoma mimicking cutis verticis gyrata is unique, and may be considered as secondary cause of cutis verticis gyrata.

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Occupational marks in a coconut tree climber

Sir,
A 40-year-old man presented with asymptomatic hyperpigmentation and thickening of skin over bilateral forearms. These lesions were not associated with itching or oozing at any time in the past. He worked as a professional coconut tree climber in various farms. On further questioning, he revealed the presence of these lesions for the past 20 years, which were the result of his using both forearms and the feet to grip the tree while climbing, as he pulled himself up to pluck coconuts. He denied using the help of any belt or support while doing so. Usually, he takes a maximum of 4-5 minutes to climb up, but comes down within 30 seconds. During this work initially, he used to suffer from minor abrasions when he had just learnt to climb, but later, he realized his skin was totally adapted to his work.

On examination, skin over both forearms on the flexural aspect was hyperpigmented and lichenified with linear striations [Figure 1] at regular intervals, resembling the bark of the coconut tree. Bilateral palms and soles showed focal yellowish callosities with loss of dermatoglyphic markings. Similar skin changes were not seen over the skin of lower legs. Nails were normal. No erythema, fresh cuts, abrasions, or erosions were seen on the skin. On the basis of the above findings, a diagnosis of frictional occupational dermatosis was made, and the patient was counselled about this.

Mechanical trauma, an accompaniment of many occupations, is the primary factor in approximately 6% cases of occupational skin diseases.[1] Friction is the most common type of mechanical trauma, ranging from mild interrupted friction, producing lichenification and hyperpigmentation, to heavier and more persistent friction, which produces callosities and nail damage.[2] The effects of trauma are modified by humidity, sweating, age, sex, nutritional status, infection, and genetic and racial factors. Friction blisters can also occur with sudden shearing force, but it seldom occurs on loose skin which stretches easily.

Occupational marks are effects of a particular occupation on the worker’s skin.[1] Earlier such marks were common among workers. Today with increasing automation, less frequent manual operation of tools, better protective clothing, such occupational marks have become less frequent.[1] Various occupations like plumbing, pipe fitting, machining, postal work, solid waste handling, athletes, musicians, computer

References


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Figure 1: Hyperpigmented and lichenified plaques with linear striations on the flexural aspect of forearms