EDITORIAL

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
Hemanta Kumar Kar, Sunil T. Sabhnani, R. K. Gautam, P. K. Sharma,
Kalpana Solanki, Meenakshi Bhardwaj .................................................................................. 136

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
<table>
<thead>
<tr>
<th>Title</th>
<th>Authors</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<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 receptors in a pediatric patient</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-trimoxazole</td>
<td>Rajiv Joshi</td>
<td>166</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: The importance of laser parameters</td>
<td>Kabir Sardana, Vijay K. Garg</td>
<td>170</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 dependent diabetes mellitus (type II): Failure of dexamethasone-cyclophosphamide pulse therapy</td>
<td>Virendra N. Sehgal, Sambit N. Bhattacharya, Sonal Sharma, Govind Srivastava, Ashok K. Aggarwal</td>
<td>171</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>
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. Raghu Rama Rao, R. Radha Rani, A. Amareswar, P. V. Krishnam
Raju, P. Raja Kumari, Y. Hari Kishan Kumar ................................................................. 185

E-IDVL
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 Kılıç .................................................................................. 187

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

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.
Alternative anti-epileptic treatment, following which the dryness and the skin lesions improved.

Zonisamide is a relatively newer anti-epileptic drug that acts by the inhibition of carbonic anhydrase. [1] Both zonisamide and topiramate (another anti-epileptic that is also a carbonic anhydrase inhibitor) have been documented to cause hypohidrosis.[2-5] Zonisamide has also been implicated in the causation of heat stroke in children secondary to oligohidrosis.[6] However, hypohidrosis is considered to be completely reversible after cessation of the drug. [6,7] The exact mechanism of oligohidrosis due to these drugs remains conjectural, although it has been postulated that carbonic anhydrase blockage at the level of the sweat gland may be a major factor.[7] In our case, we assume that hypohidrosis induced by zonisamide contributed to the sudden development of xerosis and pityriasis alba-like changes. Pityriasis alba itself is known to be precipitated by dryness of the skin.[8] This report highlights the point that in patients on zonisamide or topiramate presenting with sudden onset of dryness of the skin, the possibility of drug-induced hypohidrosis should be considered.

Feroze Kaliyadan, Jayasree Manoj, S. Venkitakrishnan
Department of Dermatology, Amrita Institute of Medical Sciences, Kochi, India
Address for correspondence: Dr. Feroze Kaliyadan, Department of Dermatology, Amrita Institute of Medical Sciences, Kochi - 682 026, Kerala, India. E-mail: ferozkal@hotmail.com

REFERENCES

Sir,
I read with interest the article ‘A modified two-step treatment for actinomycetoma’, which appeared in the July-August 2007 issue of the IJDVL.[1]

The article illustrates vividly the difficulty in definitive microbiological diagnosis of mycetomas faced by clinicians in practice as even the authors could demonstrate actinomycetes in only half of their cases and that too in a premier teaching institute.

The choice of antibiotics used in such cases is, therefore, often based on reports of previous clinical studies or reports of laboratory studies of in vitro sensitivity of human isolates of actinomyces. Combinations of two or more drugs are often used to prevent resistance and persistence of infection. However, no single regimen has given consistent good results, and successful treatment of actinomycetomas in general remains really speaking ‘a matter of chance’.

Of the 16 patients reported by the authors, 7 patients were lost to follow-up before complete healing had occurred, indicating a very high rate of drop-outs and possible waste of intensive therapy that they had received.
Earlier. Of the other 9 who did follow-up, one patient relapsed later with development of new lesions. Because mycetoma affects predominantly poor people from rural communities who often are daily wage earners, admission to hospital for intensive intravenous regimens puts them under great financial strains and results in high levels of drop-outs. I would like to report the efficacy of the combination of rifampicin and cotrimoxazole in a case of actinomycetoma.

A 58-year-old shopkeeper from a semi-rural region, about 100 km north of Mumbai, presented with swelling and induration of the right foot with discharging sinuses on the instep and the dorsum of the right foot [Figure 1]. He had been diagnosed clinically with mycetoma of the right foot 5 years back and was treated with several courses of various antibiotics (details of treatment were not available with the patient), and due to lack of response to medical treatment, he underwent surgery 1 year back to remove the affected tissue. Six months after the surgery, he started developing new sinuses and induration of the surrounding tissue.

A biopsy from one of the new sinuses revealed suppurative-granulomatous nodules within the dermis, one such area of suppuration had at its centre a collection (grain) of actinomycetes. The patient was investigated; complete haemogram, tests for G6PD function, liver and renal functions, blood sugars, urine routine and chest X-rays were found to be within normal limits. The patient had no past history of tuberculosis.

He was started on rifampicin 600 mg daily and cotrimoxazole double strength tablets (DS 1-1 or 2-2 320/1600) twice daily along with multivitamins and folic acid supplements.

He was instructed to repeat all investigations at monthly intervals at his home town and follow up for clinical examination after 2 months or earlier if he experienced any side-effects from the medication. At the first follow-up at 2 months, the lesions had started healing and by end of 4 months all lesions had healed and no new sinuses had developed [Figure 2]. Therapy was continued for a further 6 months for a total treatment period of 10 months, at the end of which he was symptom-free and continued to be so for a further follow-up period of 6 months. No adverse effects of the medication were seen.

Rifampicin is a highly bactericidal antibiotic and has been shown to be the most effective antibiotic in terms of lowest MIC amongst 13 antibiotics tested for in vitro studies against Streptomyces somaliensis, which is a cause of human actinomycetoma. Rifampicin has also been used along with amikacin and co-trimoxazole in the successful treatment of nocardiosis of the chest wall that developed 10 years after untreated mycetoma of the right hand.

Therefore, in my opinion, rifampicin along with cotrimoxazole for extended periods of time may be a rational initial choice for treatment of actinomycetomas, as this combination is fairly cheap and can be used at home by the patient without the need for admission to a hospital.

Most patients do not receive therapy for adequate period of time (several months to even years of treatment may be needed), and for patients who do not improve even after a reasonable trial with these two drugs, intensive therapy with intravenous penicillin and gentamicin or amikacin may be attempted.

Figure 1: Actinomycetoma with sinuses on instep of right foot at presentation

Figure 2: Complete healing at 4 months with previous surgery scar
Rajiv Joshi
P. D. Hinduja National Hospital, Veer Savarkar Road, Mahim,
Mumbai, India

Address for correspondence: P. D. Hinduja National Hospital, Veer Savarkar Road, Mahim, Mumbai - 400 016, India.
E-mail: rsjdr@rediffmail.com

REFERENCES