Figure 1: Verruca plana following eyebrow threading

Figure 2: Histomicrograph showing hyperkeratosis of loose lamellar type, acanthosis without papillomatosis or parakeratosis. Numerous vacuolated cells lie in the upper stratum malpighii, including granular layer. The horny layer had a pronounced basket-weave appearance resulting from the vacuolization of the horny cells (H & E, x200).

Verruca plana may develop in men who shave their beards and in women who shave their legs. This is a result of autoinoculation of the HPV. A useful finding is the tendency of the warts to koebnerize, forming linear, slightly raised papular lesions. Multiple warts are reported that develop after tattooing and remaining exclusively confined to that area. The latent virus has the ability to induce wart after cutaneous ultraviolet exposure. Appearance of warts at the site of threading is an unusual phenomenon. Kumar et al. reported two such cases, the first as Koebnerization from the initial lesion elsewhere on the patient's body, and the second possibly from the infected material at the beauty parlour. In our case, appearance of verruca plana is due to use of infected material at the beauty parlour followed by Koebnerization.

Thus, beauty parlour personnel should neither reuse the thread during threading nor use the same towel on multiple clients. Moreover, they should properly sterilize the instruments (scissors and forceps) used for threading and facials to avoid this cross infection. We report this case for its rarity.

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DOI: 10.4103/0378-6323.48679 - PMID: 19293519

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Blepharochalasis

Sir,

Blepharochalasis is a rare degenerative disease of the skin of the eyelids, characterized clinically by bilateral or unilateral swelling followed by laxity, atrophy, wrinkling and pigmentary changes, predominantly of the upper eyelids. The skin of the eyelids becomes so lax that it droops as redundant folds over the lid margins. The term blepharochalasis was first coined by Fuchs in 1869, meaning eyelid relaxation in Greek. It is also termed ptosis atonia, ptosis adipose and dermatolysis palpebrum.
Letters to the Editor

A 21-year-old female presented with laxity of the skin of the upper eyelids for the past 4 months. The problem first manifested at the age of 16 years, when she developed mild fever of 2 days duration followed by bilateral periorbital swelling. This was followed by a gradual increase in the laxity of the skin of the upper eyelids. She underwent cosmetic blepharoplasty in the plastic surgery department of our hospital 3 years ago. Initially, the results were good but, after 1 year, the skin again became lax following eyelid swelling. She was not given any medical treatment and was advised repeat blepharoplasty after stabilization of her condition. Her family history was not contributory and her twin sister did not have similar complaints.

Local examination revealed lax wrinkled skin of the upper eyelids with no pigmented changes [Figure 1]. The skin at other sites was normal. There was no swelling of the lips or the thyroid region. Her systemic examination was normal. Complete hemogram, liver, renal and thyroid function tests were normal.

The exact etiology of blepharochalasis is not known. Most of the cases are sporadic, but autosomal-dominant inheritance has been noted in a few pedigrees.[1] The condition develops insidiously around puberty, characterized by repeated transient attacks of swelling of the eyelids lasting for a few days, followed by laxity, atrophy, wrinkling and pigmented changes predominantly involving the upper eyelids, although involvement of the lower eyelids[4] and unilateral involvement has been reported.[3] Systemic conditions associated with blepharochalasis are renal agenesis, vertebral abnormalities and congenital heart disease.[5] The eyelid changes cause a lot of cosmetic disfigurement and the affected person looks prematurely aged. About 10% of the cases may have reduplication of the mucous membranes of the upper eyelid, causing apparent thickening of the lids.[1]

Three stages are described in the evolution of blepharochalasis.[2] The first is the recurrent angioedema, while the second stage, which is characterized by discolored, flabby and lax skin, is called the stage of atonic ptosis. In the third stage, there is further relaxation of the tissues of the orbital septum, with prolapse of the orbital fat leading to interference of vision. This stage is called ptosis adipose. Most of the cases are reported in the second stage, as in our case.

Blepharochalasis can be diagnosed with the help of a proper history and characteristic skin changes of the eyelids.[3] Histopathological examination in the early stages shows mild dermal lymphocytic infiltrate while in the late stages, elastic tissue of the lids is fragmented and decreased.[6] A recent report described immunoglobulin A deposits in the residual elastic fibers, implying the involvement of an autoimmune mechanism.[7]

The only effective treatment is correction by plastic surgery after the disease has run its course, otherwise subsequent attacks of lid edema may interfere with the results.[8] Blepharochalasis may be associated with progressive enlargement of the upper lip due to enlargement of the labial salivary glands as well as thyroid swelling in Asher’s syndrome.[8] Ptosis, a common genetic defect, can be distinguished due to the normal appearance of the skin. Generalized cutis laxa and Ehlers–Danlos syndrome may have a similar appearance, but are easily distinguished due to other clinical features.[1] We are reporting this case because of its rare occurrence and its probable relation to fever.

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DOI: 10.4103/0378-6323.48680 - PMID: 19293520

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Figure 1: Lax wrinkled skin of the upper eyelids
Letters to the Editor

An 83-year-old man presented with multiple ulcerated lesions on his arms, chest, back and legs of 1 year duration. He noticed multiple nodules that progressively increased in size and ulcerated spontaneously in the center. There was no history suggestive of any preceding skin change or dermatitis. He was initially treated in another hospital as pyoderma gangrenosum with prednisolone (1 mg/kg) to which he had a partial response, but lesions recurred and continued to increase in size and ulcerate. His past medical history was unremarkable. He was a chronic smoker. There was no history of anorexia, weight loss, fever or night sweats.

On cutaneous examination, multiple, irregular, hard, mobile, nodoloulcerative lesions, largest measuring 13 cm x 10 cm in size, ulcerated in the center and covered with greenish slough were seen over the medial aspect of both arms [Figure 1], and left forearm, left thenar eminence, and medial aspect of the left flank. The edges of the ulcers were raised and overhanging. The surrounding skin was violaceous and indurated. Two unulcerated nodules were also seen over the back. There was no significant regional lymphadenopathy. Systemic examination was unremarkable and no organomegaly was noted.

Histological examination of the skin lesion on the left arm showed a dense infiltrate of mononuclear cells throughout the dermis and subcutis with prominent epidermotropism, with lymphocytes lying singly as well as in groups. Large cell transformation was seen. Immunohistochemistry revealed the tumor cells to be CD3 and leukocyte common antigen positive while being negative for CD30 and CD20. Haemogram, routine blood biochemistry, ultrasound of the abdomen and computerized tomography scan, chest X-ray and urine analysis were normal. Peripheral blood smear, bone marrow aspiration cytology and biopsy examination were negative for atypical cells. Retroviral serology was negative. Pus swab culture and skin biopsy specimen sent for culture from the ulcer grew *Pseudomonas aeruginosa* sensitive only to amikacin.

Based on the clinical and histopathological findings, a diagnosis of tumor d’emblee type of MF (Stage IIb) was made. The patient was treated with a course of antibiotics and daily wet dressing. Subsequently, he was started on single-agent chemotherapy with methotrexate (0.25 mg/kg) weekly along with prednisolone (1 mg/kg) daily. The skin lesions improved slowly and steadily, and after 1 month of treatment, the patient showed regression of more than 70% of the lesions [Figure 2]. On follow-up after 4 months, only two ulcers remained, which were also healing well without any evidence of dissemination.

Primary cutaneous lymphomas represent the second most common extranodal site for non-Hodgkin’s lymphoma. CTCL is a heterogeneous group with diverse clinical manifestations, which represents about 80% of all primary cutaneous lymphomas. [1] The most common CTCL is MF. However, other lymphoproliferative diseases also involve the skin, including Ki-1+ anaplastic large cell lymphoma, peripheral T-cell lymphoma, cutaneous B-cell lymphoma, adult T-cell leukemia/lymphoma, T-cell