we were reluctant to perform the investigation.

2) Most reliable method for demonstration of amyliod is the study of Congo red stained section under polarised light.[1] Unfortunately we couldn't avail that advantage due to lack of facility.

3) We included only those cases of macular amyloidosis which were having typical clinical features at typical sites, with characteristic reticulated or rippling appearance etc. A few cases only may be confused with other disorders. Cases with even least doubt were not included in the study.

4) In this context, it will not be out of place to mention that in a study of cyclophosphamide therapy in lichen amyloidosis, Pasricha and Seetharam included patients 'having characteristic lesions'[2] without any biopsy.

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ULCERATIVE LICHEN PLANUS OF THE FOOT

To the Editor,

Lichen planus (LP) is a common skin disorder of unknown aetiology having various morphological variants. Ulcerative and bullous forms are extremely rare and that mimicking granulomata are still rarer. These granulomatous forms often cause diagnostic problems unless they are associated with lesions of lichen planus elsewhere over the body. Ulcerative and bullous LP of the feet with permanent loss of toe nails alongwith cicatricial alopecia of the scalp[1] and ulcerative LP of the feet with serological findings of SLE[2] have been described. The ulcerative lesions are important because they can be a site for epitheliomatous transformation.[3]

A 40-year-old female patient had a big painful ulcer 2x2 cm on the ventral aspect of her left foot for 3 years. The ulcer was having a granulomatous base with irregular margins. She also had two hypertrophic lesions on either side of the ulcer. Toe nails were normal. After about 2 years she developed lesions in the buccal mucosa and lower lip that on examination showed white streaks forming lace-like pattern alongwith few violaceous patches characteristic of LP. From the association of these lesions with those of the foot, she was diagnosed as a case of ulcerative LP of the foot mimicking chronic granulomata. The diagnosis was confirmed with biopsy. She was given dapsone 50 mg tid along with topical corticosteroids. She showed dramatic response and the lesions healed within 3 months.

Ulcerative LP of the feet usually involves the toe nails causing their destruction and gradual shedding.[1] Patients have chronic, progressive, crippling, erosive and ulcerative lesions resulting in scarring and deformities.Our patient showed chronicity and progression but the toe nails were not involved and no epitheliomatous changes were seen. Dapsons has given good results in such cases as we have seen in our patient.

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EPIDERMODYSPLASIA VERRUCIFORMIS

To the Editor,

Epidermodysplasia verruciformis is a rare condition characterised by widespread and persistent infection with human papilloma virus (HPV) types 5,8,9,12,14.[1]

A 7-year-old boy presented with numerous, discrete and confluent, greyish black, pinhead sized, flat topped papules over the scalp, forehead, back of both auricles, face, neck, front and back of the trunk of 6 months duration. In addition, there were multiple, small (1-1.5cm) discrete, scaly, hypopigmented macules over front and back of the trunk, resembling pityriasis versicolor. The histological picture confirmed the clinical diagnosis of epidermodysplasia verruciformis. He was given 0.025% tretinoin cream topically twice daily and topical sunscreens. Within two months, the lesions flattened, but did not disappear entirely.Long term prognosis will require regular surveillance and follow up.

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CONTACT LEUCODERMA CAUSED BY LEMON

To the Editor,

Contact leucoderma has been reported with bindis and footwear.[1,2] It is caused mainly by paratertiary butyl phenol used in adhesives of bindi and footwears.[3] We are reporting an unusual case of contact depigmentation due to lemon which was rubbed over the face.

A 20-year-old girl presented with patchy depigmentation which she developed after 5 days of rubbing fresh lemon over the face. After few hours of rubbing, she felt burning over the site. On second day of application she developed redness, itching and scaling. After exfoliation lesions healed within 5 days and left depigmented patches.

Contact depigmentation may be due to direct toxic effect of chemicals on melanocytes[4] or due to development of immunological reaction (contact dermatitis) followed by depigmentation as in bindi dermatitis.[5] In our patient the depigmentation produced by lemon was probably because of direct toxic effect over melanocytes as patch test to lemon juice was negative.

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