LETTERS TO THE EDITOR

SEGMENTAL VITILIGO AND LICHEN PLANUS OCCURRING OVER THE SAME SITE

Vitiligo and lichen planus are unrelated disorders, though in recent years the former is widely believed to be of autoimmune origin. We are reporting a case who had both these disorders distributed in a segmental pattern over the same site.

A 19-year-old male complained of mildly pruritic skin eruptions over his genitals, and white patches over the same area including the right buttock, of 4 months and 2 years duration respectively. The eruptions had commenced as erythematous papules which gradually enlarged to form small plaques and on regression over the course of time left depigmented areas. No specific advice or therapy was taken for any of these conditions in the past because these were relatively asymptomatic.

Examination revealed multiple, violaceous, flat-topped scaly papules, localised on the right half of glans penis, inner prepuce, penile shaft and the scrotum. Papules over the dorsum of the penis had coalesced to form a 1 cm long plaque. Lesions over the ventral part of penis and right half of scrotum showed a light grey hue, mild scalyness and hypopigmentation at places which in a linear progression merged indistinctly with the border of the depigmented macule over the inguino-scrotal fold of the same side; this macule showed poliosis and measured 3 cm × 1.5 cm. Similar depigmented macules, 3 in number, varying in size from 0.5 cm to 1 cm were seen over the medial part of the right buttock and perianal region. Routine blood and urine tests were normal. Histopathology from three respective sites confirmed the diagnosis of vitiligo and lichen planus. One of the biopsies taken from the lesion over the penile shaft showed a sparse infiltrate of lymphocytes in the upper dermis, reformation of the basal cell layer and decrease in the number of melanocytes, denoting a transitional phase of the lesion from lichen planus to vitiligo.

Lichen planus and vitiligo are both known to have linear, segmental or zosteriform patterns of distribution of the disease and Koebner or isomorphic phenomenon. Occurrence of these two conditions over the same segment, as in our patient, is interesting and hitherto unobserved.

Healed lesions of lichen planus usually leave a striking hyperpigmentation, and infrequently hypopigmentation.[1] Vitiliginous macules following lichen planus in our patient may be attributed to either Koebner phenomenon and/or presence of a vitiligo diathesis, with trauma i.e. epidermal injury due to lichen planus inducing typical vitiligo.[2]

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MUTILATING PALMO-PLANTAR KERATODERMA (VOHWINKEL DISEASE) WITH CONGENITAL DEFORMITIES

Mutilating palmo-plantar keratoderma is a dominantly inherited disorder.[1] Several disorders have been associated with Vohwinkel disease but to the best of our knowledge, its association with congenital cleft palate has not been described in the literature so far.

We observed a 12-year-old male child who had nasal intonation of voice since birth. Thickness of both palms and soles was noticed in early childhood which initially involved only a small area but slowly the entire palmar and plantar surfaces on both sides became thickened. At the age of 10 years he developed constriction around both the fifth toes with pain and swelling. The general and systemic examination was within normal limits. Oral examination revealed cleft palate (Fig. 1). The hyperkeratosis was more marked on the distal halves of palms and soles. Both fifth toes had ainhum. There was no evidence of ichthyosis, hearing loss, alopecia or acanthosis nigricans. The haemogram, urine and stools examination were within normal limits. X-ray of both feet revealed mild hallux valgus deformity. The patient was treated with topical keratolytic agents and the fibrous constrictions at the base of 5th toes was released by multiple longitudinal incisions.

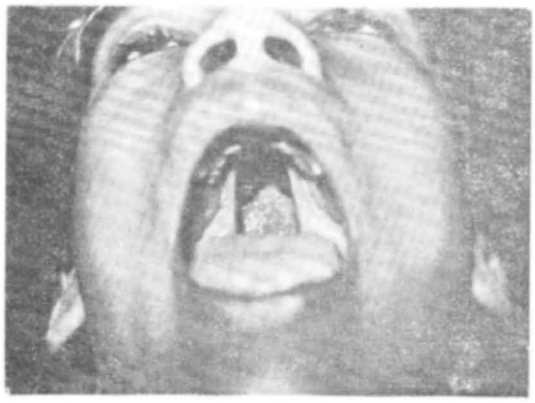

Fig. 1. Cleft palate.

Only 8 cases have so far been reported among Indians.[2] The association of ichthyosis vulgaris, epidermolytic hyperkeratosis, acanthosinigs ricans, severe degree hearing loss, alopecia, pseudopelade, transient plantar bullae and ainhum has been reported. Involvement of the phalanges and the metatarsal bones of both feet has also been reported in the literature.[3]

Our case had classical findings of Vohwinkel disease associated with congenital cleft palate and bilateral hallux valgus which have not been reported so far in the literature. The occurrence of similar disease in the family could not be ascertained as the patient was an orphan. It is difficult to say whether this association is just a chance occurrence or it is related to Vohwinkel disease.

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POLYONYCHIA (SUPERNUMERARY NAIL ON THUMB)

Recently, a 13-year-old boy born to non-consanguinous parents was seen for a supernumerary nail on the right thumb, present since birth. There was no history of trauma and none in his family had similar nail disorder. Examination revealed a small nail on the dorsum of the right thumb, 1.5 cm proximal and slightly lateral to the proximal nail fold of the normal nail of the thumb (Fig. 1). The skin between the two nails appeared normal. The additional nail was measuring 0.6×0.3 cm in size and had a proximal and two lateral nail folds. The nail plate was 3 mm long and had a distal free margin which grew at a rate of 0.05 mm per day. There was no lunula in this nail. Other parts of the nail like nail grooves, cuticle, eponychium and yellow line were seen. All the other 20 nails of the fingers and toes were normal. Skiagram of the hand did not show any abnormality of the bones of the affected thumb.

Fig. 1. Polyonychia of the right thumb.

In the present case, the clinical features suggest a polyonychia which is characterized by 2 or more nails entirely separated from each other, existing on a finger or a toe. Polyonychia is an extremely rare congenital anomaly.

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