deficiency 5-15mg. riboflavin two times daily for two weeks is curative. Simple emollients make skin moist, reduce intensity of itching. Tricyclic antidepressant doxepin 25-50mg. per day helps some patients. Anxiolytic alprazolam or antipsychotic thioridazine is helpful in some. Systemic or topical therapy has to be given intermittently for a long time.

References

1. Goldsmith G A. In : Beaton GH, Mc Herry EW, eds. Nutrition vol.2. New York; Academic Press, 1994.

2. Rook A, Wilkinson DS, Ebling FJG, et al, eds. Textbook of Dermatology, 5th Edn, Blackwell Scientific Publications, Oxford 1992; 2364.

Dilip Kumar Nath 8/A/3/ officers quarters 507, Army Base Workshop P.O. ESD (M), Kankinara Dist. North 24 Parganas (WB)

ANNULAR ERYTHEMATOUS LESION SECONDARY TO IMMUNOTHERAPY

To the Editor

Immunotherapy is a relatively safe treatment. However systemic and cutaneous side effects can occur.[1] We report a case of annular erythematous lesion at the injection site in a patient receiving immunotherapy.

A 36- year- old male photographer was referred to the Dermatology department for evaluation of a skin rash following desensitization injections. He was suffering from allergic rhinitis since 8 years and had been prick tested with 22 allergens consisting of mite, pollen, fungi, insects, dusts, danders and foods obtained from Allergen Division Curewell (India) Ltd. He was tested positive for the following : Pollens - *Chenopadium ablum, Ricinus communis , Cassia siamea;* insects - Male and female cockroaches; dog epithelia; culvularia fungus and house dust mite. Immunotherapy was commenced with a mixture of allergens.

The patient initially received two injections per week from a vial containing 1:5000 dilution of the solution without developing any side effects . When injections with 1: 500 solution were commenced he developed pruritic erythematous papular lesions in an annular fashion around the injections site. The lesion used to appear within 24 hours and resolve completly within 10 days without any residual pigmentation or scarring. He developed this lesion following each injection taken weekly. No lesions appeared in other parts of the body and there was no history of angioedema. A skin biopsy revealed epidermis with foci of mild spongiosis and exocytosis of inflammatory cells. Dermis showed moderate perivascular and peri-follicular lymphocytic infiltrate.

Various dermatologic manifestations following desensitization treatment reported include local urticarial reactions which are by far the most common,[2] others being digital vasculitis,[3] persistent, itchy subcutaneous nodules[4] and cold urticaria.[5] In our case the skin lesion could have been a delayed hypersensitivity reaction as the patient developed it later in the course of therapy, sensitization having been induced with the initial injections.

Shrutakirthi D Shenoi
Munish Paul
Kasturba Medical college
Manipal - 576119, India.

References

1. Luigi A, Senna G, Mezzelani P, et al. Safety of specific immunotherapy : a retrospective study, Invest Aller Clin Immunol

1994; 4:250 - 254.

2. Varney VA, Gaga M, Frew AJ, et al . usefulness of immunotherapy in patients with severe summer hay fever uncontrolled by anti allergic drugs, Br Med J 1991; 302:265 - 269.

3. Cabrera GE, Citera G, Gutierrez M, et al. Digital vasculitis following allergic desensitization treatment. J Rheumatol 1993; 20 : 1970 - 1972.

4. Garcia Pastos V, Almorar A, Lleonart R, et al. Subcutaneous nodules and sensitivity to aluminium in patients undergoing hyposensitivity immunotherapy. Med Cutan Ibero Lat Am 1990: 18 : 83 - 88.

5. Anfosso - Capra F, Philip Joet F, Reynaud - Gaubert M. et al. Occurrence of cold urticaria during venom desensitization. Dermatologica 1990 ;181 : 276 - 177.

CREEPING ERRUPTION

To the Editor

Recently we have come across a case of creeping eruption in a 6-month-old infant on the back of trunk. A 6-month-old female child was brought to the Dermatology OPD with a tortuous, linear narrow lesion on the back of trunk of 3-4 weeks duration. It started as a red papule from which a linear cord-like lesion progressed. Mother of the child used to lay her child on ground during working in field. Examination revealed a linear and curved erythematous track of 1 to 1.5 cm. As the tunnel advanced on one end, the opposite end became scaly, crusted and finally cleared. There was no other skin lesion. General physical and systemic exmination did not reveal any abnormality.

Routine laboratory investigations on blood, urine and stool were normal. Two tablets of 500 mg thiabendazde, triturated in 10 gm petrolatum was applied twice a day over the lesion. The track cleared within two weeks.

Cutaneous larva migrans (creeping eruption) is caused by the larva of nematode parasites for which man is abnormal final host. *Ancylostoma braziliense* is the most frequent cause, though the larva of other hook worms may also produce it. The common area of skin involved are the feet, buttocks and hands, though rarely it has been reported from other sites also.[1,2] In present case lesion was on back which is thought to be uncommon site in this part of the country. Demonstration of a persistent, progressive, erythematous, serpiginous eruption on common site of skin is usually suffcient for the diagnosis. Occurrence of larva migrans in the infant is quite rare though few cases have been reported.[2,3] A 68-day-old child has been reported with larva migrans of 65 days during a precipitated labour.[3] In our case age and site are unusual which prompted us to report this case.

B L Masuria
A Batra
R K Kothiwala
R Khuller
M K Singhi

Department of Dermatology, Venereology and Leprology, Dr. SN Medical college, Jodhpur, Rajasthan

References

1. Pavithran K. Larva migrans on the glans penis. Indian J Dermatol Venereol Leprol 1982; 48: 237- 238.

2. Sinha SM, Chakraborty P. Cutaneous larva migrans. Indian J Dermatol Venereol Leprol 1977; 43: 170.

3. Sarojini PA, Khaleel S, Basheer AM. Larva migrans. Indian J Dermatol Venereol Leprol 1977; 43: 336.