was added in this base. The preparation adheres to the oral mucosa for a long time and can be applied twice daily.

We treated 20 patients with oral LP of varying severity with this preparation applied topically twice a day. A remarkable improvement in 16 (80%) patients was noticed after 4 weeks of use. Ten out of 20 (50%) patients showed complete clearance after 3 to 4 months. They are on regular follow up to detect any signs of recurrence. No side effects have been noticed. We propose topical triamcinolone acetonide in indigenous orabase as the treatment of choice due to its cost effectiveness, safety and excellent therapeutic efficacy.

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ALOPECIA AREATA AND XEROSIS IN DOWN'S SYNDROME

To the Editor,

A 4 years 9 months old girl reported with the history of repeated respiratory tract infection. On examination she had typical Mongol face and congenital heart disease (VSD) with left to right shunt. Skin examination showed dry skin all over the body with loss of hair on four places of scalp. Diagnosis of Down's syndrome was established by clinical finding and karyotyping chromosomal analysis. Alopecia areata occurs in Down's syndrome in older children.[1] In our patient alopecia areata started when child was 11 months old .

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AIDS RELATED KAPOSI'S SARCOMA-LIKE LESION

To the Editor,

Kaposi's sarcoma (KS) is the commonest neoplasm in persons infected with HIV. India has the largest number (68%) of HIV infected individuals among the countries of South-East Asia. The major mode of transmission of HIV in India is through sex (75%)[1] but in Manipur the major route is through injection (52%).[2] HIV associated KS is thought to be rare in this part of the World but this may not remain so in future. No proved case of KS has been reported so far from Manipur.

We have suspected a 22-year-old male suffering from AIDS related KS. The patient presented with occasional cough, haemoptysis, fever, loss of appetite and darkening of complexion for approximately 6 months. Macules and papules started to appear 2 months later in the trunk and gradually became generalized. They were reddish in colour to start with and later became dark brown, there was no associated pain or itching. There was also a history of difficulty in swallowing food for 1 month. He slowly

became weaker and bedridden, the loss of body weight was more than 10%.

The patient was an injecting drug user for approximately 5 years since 1987 Sharing of the unclean needle and syringe with partners was present. There was no history of sexual experience. The person was unmarried. He did not have a history of any sexually transmitted disease (STD). He was treated in the past by several courses of antibiotics and vitamins but to no avail.

On examination, the patient was pale, wasted, generalized lymphadenopathy and skin lesions were present. Oropharyngeal candidiasis was also noted. No abnormality was detected in the respiratory, lower gastro-intestinal tract, cardiovascular, genito-urinary and central nervous systems. The skin lesions were papulonodular, dark reddish in colour and did not blanch on pressure, the density of the lesions was maximum in the front and back of the trunk.

Investigations : haemogram normal except haemoglobin 10.2 gm%, ESR 105 mm in 1st hour, Mantoux test 0 mm after 48 hours, sputum for acid fast bacilli negative, chest X-ray normal, antibody against HIV positive (by ELISA and Western Blot Method). Histopathological examination of a skin nodule revealed no definite evidence of Kaposi's sarcoma (mild acanthosis and papillomatosis with hyperkeratosis was noted, the upper epidermis showed few vascular channels with a sprinkling of round cell infiltrate).

Kaposi's sarcoma is a multifocal endothelial cell-derived tumour which primarily affects the skin but may involve other tissues as well.[3,4] It is often the presenting clinical manifestation of AIDS. HIV is not the direct cause of Kaposi's sarcoma and there is no evidence of malignant transformation of cells. The course of Kaposi's sarcoma ranges from indolent, with only skin manifestations to fulminant with extensive visceral involvement. Although any organ system can be involved in the disseminated form, lymph nodes, gastrointestinal tract and lungs are most commonly involved. The skin lesions generally present as papules or plaques that ultimately evolve into nodules. Lesions can occur at any location, but the face is a common site, specially the tip of the nose and pinnae of the ears.

Histologically, slit-like spaces lined by flattened cells supported by groups of spindle cells which are admixed with red cells and haemosiderin are characteristic. A diagnostic though rare feature is the presence of eosinophilic globules in the cytoplasm of spindle cells.[5]

A variety of skin conditions may be considederd as differential diagnosis in this case. Fixed drug eruption presents with erythematous or hyperpigmented macules and sometimes bullae but papules and nodules are not the features. Papules, nodules and plaques may all be present in lichen planus but the lesions are intensely itchy. Lichen prurigo and prurigo nodularis are again irritable hypertrophic papules and nodules. Lichen simplex chronicus are usually lichenified plaques at typical sites. Multiple neurofibromatosis lesions are soft skin coloured nodules. Nodules and tumours are also seen in mycosis fungoides and Hodgkin's disease but they show characteristic histological features. Cutaneous mycobacterial infections have typical clinical and histological features.

In view of the frequent association of AIDS with Kaposi's sarcoma, Kaposi's sarcoma like lesion may be considered clinically in this HIV positive patient though the characteristic histological features could not be

obtained in this case. The papules and nodules in present case did not fit at least clinically into any of the other skin diseases.

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WHY LESIONS OF MORPHOEA ARE OFTEN HYPERPIGMENTED?

To the Editor,

The lesions of morphoea are characterized by indurated areas of skin, which at first are faintly purplish or mauve in colour. After a few weeks or months, they lose their colour, especially in the central part and appear as thickened waxy ivory coloured areas with a characteristic lilac border.[1] In Indians with mostly type IV or type V skin colour, we rarely appreciate the purplish or mauve colour and lilac border in the lesions of morphoea. Instead, in most of our patients we observe mild hyperpigmentation over the morphoea plaques. In the standard text[1] these hyperpigmented patches are stated to be present at the very beginning of morphoea lesion(s) or at the site of resolving plaque(s). However, we see these patches mostly over the well developed plaques of morphoea. The pathomechanism of such hyperpigmentation has not been elucidated in the standard textbooks.[1,2]

We have been interested to look into this aspect and to find out the status of melanocyte and basal cell layer in the histopathological sections of morphoea lesions. On Fontana-Masson stained sections, we have found that there is increased melanocytic activity in the form of prominent melanocytes in the basal cell layer. It appears that there is increased melanin synthesis inside the melanocytes. There is no basal cell degeneration and melanin incontinence. The first author has been observing this histopathological phenomenon for the last 6 years.

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CLEARANCE OF PLAQUE PSORIASIS FOLLOWING IRRITATION DUE TO CALCIPOTRIOL

To the Editor,

A 9-year-old girl presented with extensive plaque psoriasis of 3 months duration. In view of inadequate response to topical coal tar and steroid therapy, calcipotriol (50 µg/g) was started. Patient developed irritant reaction to topical medicament within a