Authors' reply

Sir,

We thank the authors for their interest in our article on the controversies surrounding the nosology of ashy dermatosis, lichen planus pigmentosus and pigmented cosmetic dermatitis.[1] These entities share several clinical and histopathological features, and their nomenclature has been debated endlessly.[2-7] The focus, so far, has been more on highlighting the subtle differences between them, instead of finding answers to the more meaningful questions such as their etiopathogenesis, natural course and effective treatment options. Lack of consensus on the nomenclature of these poorly understood disorders has only hindered research in this field. We prefer "lumping" to "splitting" these remarkably similar entities to facilitate communication among dermatologists and researchers, and think of them as a clinical reaction pattern with several poorly understood triggers. Although the authors largely concur with our unifying idea, they differ on the choice of the umbrella term and favor "*acquired dermal macular hyperpigmentation of varied etiology*." We would like to point out that our objective was not to propose another term, but rather to question the need for different terms for what appears to be spectral manifestations of a single disease process. We simply reiterated the term ("*macular pigmentation of uncertain etiology*") which was already in existence to avoid further confusion.[4] Recently, a global consensus statement on the terminology of these conditions has been released which states that lichen planus pigmentosus, ashy dermatosis and erythema dyschromicum perstans are in the spectrum of *acquired macular pigmentation of uncertain etiology*.[8]

The proposed name "*acquired dermal macular hyperpigmentation of varied etiology*" by the authors is a good descriptive term, especially as it emphasizes the dermal location of the pigment. However, we feel that the current knowledge regarding the etio-pathogenesis of these conditions is not sufficient to justify the phrase *'of varied etiology'* in the name. Some of the 'etiologies' such as hepatitis C infection are probably just an association,[9] while the role of hormonal factors has been speculated owing to the frequent occurrence of lichen planus pigmentosus in perimenopausal women.[10] Although photosensitizers such as amla oil and mustard oil have often been implicated as causative factors, there is no conclusive evidence to support this hypothesis.[11] In fact, the global consensus forum concluded "these conditions are unlikely to be due to a particular oil applied on the skin or a particular dietary ingredient" because of the diverse cultural practices in different regions where these diseases occur.[8] We have previously reported patch test positivity in about one-third of our patients with lichen planus pigmentosus on face.[12] Similar results have been reported by others as well, raising the possibility of certain contact allergens triggering the disease in a subset of patients.[5,13] However, the etiology remains largely unknown in the vast majority of patients and mandates further research. Indeed, the phrase "of uncertain etiology" may serve as a reminder of the uncertain aspects of this enigmatic group of pigmentary dermatoses and give a fresh impetus to our efforts in identifying their cause.

The authors further contend that entities such as fixed drug eruptions, melasma, ochronosis, macular amyloidosis, drug-induced and post inflammatory hyperpigmentation, nevus of Ota and other dermal melanocytoses could also be encompassed in the term *acquired macular pigmentation of uncertain etiology*. However, etiology, and even pathogenesis, of several of these conditions is no longer uncertain; for example, drug eruptions (T-cell-mediated delayed hypersensitivity to drug hapten),[14] exogenous ochronosis (long-term hydroquinone use or related

products),[15] macular amyloidosis (constant friction)[16] and postinflammatory hyperpigmentation (sequelae of an inflammatory dermatosis). In fact, it is suggested to exclude hyperpigmented macules with a definite etiology (such as drug eruption, postinflammatory) from this rubric.[8]

Lastly, we feel that the "name" itself may not be so relevant as long as a consensus is reached, and its connotations are understood clearly by the researchers worldwide. We hope that this debate on the nomenclature ends soon, and the focus is shifted to furthering meaningful research that can translate into results for our patients suffering from this distressing condition. The nomenclature can be changed as new information comes to light.

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Conflicts of interest
There are no conflicts of interest.

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