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BODY HAIR DISTRIBUTION OF WOMEN ATTENDING ENDOCRINE OPD

To the Editor,

There is no difference in the number of hair follicles per unit area of face in individuals of different races, yet there is difference in extent and degree of growth of hairs in androgen sensitive areas.[1] Apart from racial factor, hormonal status also alters the body hair distribution. There is scarcity of data on body hair distribution among Indian women.[2]

We assessed body hair distribution in 611 randomly selected female patients attending Endocrine OPD. Among women not complaining hirsutism significant hair growth was present in 17.16% on upper lip, 7.87% on chin, 1.22% on chest, 2.8% on lower back, 2.10% on upper abdomen, 4.2% on lower abdomen, 3.32% on arms, 6.82% on thighs, 30.92% on forearms and 40.92% on legs. Significant hirsutism (Ferriman Gallwey score more than 9) was present in 84 (13.73%) cases, of them only 40 (7.55%) sought medical help for this. They had moderate to severe hirsutism (score 19.17+52). Complete diagnostic evaluation was possible in 63 of the 84 cases. Congenital adrenal hyperplasia (CAH) (including classical, late onset and heterozygous state) was the commonset cause (26.94%), followed by polycystic ovarian disease (PCOD) and hypothyroidism (17.64% respectively). Idiopathic hirsutism was present in 11.11% cases. 12.70% had drug-induced hirsutism (glucocorticoids, anti-epileptics, anti-psychotic and progestinal preparations). Acromegaly, Cushing's syndrome, ovarian tumour and prolactinoma were present in 6.35%, 4.76%, 1.59% and 1.59% patients respectively.

We concluded from this study that women from Delhi seek medical help for hirsutism only when it is of considerable severity. Among women with moderate to severe hirsutism contrary to previous Indian reports[3,4] prevalence of CAH is quite high.

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TOPICAL VITAMIN A IN EXFOLIATIVE CHEILITIS

To the Editor,

I wish to share my experience on exfoliative chelitis (Ind J Dermatol Venereol Leprol 1995: 61:132). Two cases, a 24-year-old Lebanese male and a 19-year-old Indian female presented with chronic cracking, crusting and peeling of skin of lower lip. Itching was absent, there was mild pain. Removal of crust revealed a glazed surface. Oral and topical steroids, antifungals and antibacterials were used previously with no benefit. There was no history suggestive of contact allergy.

Topical, intralesional, intramuscular steroids,[1] and beta radiation,[2] have been