activity of itraconazole. In: Fromtling RA, ed. Recent Trends in the Discovery, Development and Evaluation of Antifungal Agents. JR Prous Science Publishers SA, 1987: 177-192.

6. Cauwenbergh G, Degreef H, Heykants J, et al. Pharmacokinetic profile of orally administered itraconazole in human skin. J Am Acad Dermatol 1988; 18: 263-268.

Acknowledgement

We thank Glenmark Pharmaceuticals Ltd who supplied Itraconazole (Canditral) capsules to conduct this study. We also thank Mr Deshpande, the pharmacist who helped in preparing the coded itraconazole and placebo capsules.

PEYRONIES DISEASE, SCLERODERMA AND DIABETES MELLITUS

To the Editor

A 55-year-old man, known case of diabetes mellitus with hypertension presented with features of scleroderma (scleroderma, Raynaud's phenomenon and difficulty in swallowing) of 3 months duration. He also complained of impotence and increased curvature of penis on erection for the past 2 months.

Skin biopsy findings were consistent with scleroderma, ANA was negative and ultrasonography revealed hyperechoeic area in the upper third of penis suggestive of Peyronies disease. Prevalence of diabetes mellitus is reported higher in patients with Peyronies disease[1] and association with systemic sclerosis has also been documented in recent literature.[2,3] Etiology of Peyronies disease remains a mystery, and recent studies on HLA antigens and immunological features suggest the hypothesis of an autoimmune etiology for the disorders.[4,5] Peyronies disease co-existing with scleroderma and diabetes mellitus in the present case corroborates autoimmune basis of the disease.

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References

1. Culha M, Alici B, Acar O, et al. The relationship between diabetes mellitus, impotence and veno occlusive dysfunction in Peyronies disease patients. Urol Int 1988; 60:101-104.

2. Ordi J, Selva A, Fonollosa V, et al. Peyronies disease in systemic sclerosis. Ann Rheun Dis 1990; 49: 134-135.

3. Gualdieri L, Valentil G, Lupoli S, et al. Peyronies disease in systemic sclerosis. Report of two cases. J Rheumatol 1988; 15: 380-381.

4. Rompel R, Mueller - Eckhardt G, Shroeder - Printzen I, et al. HLA antigens in Peyronies disease. Uro Int 1994; 52: 34-37.

5. Schiavino D, Sasso F, Nucera E, et al. Immunological findings in Peyronies disease. Urology 1997;50:764-768.

NEVUS DEPIGMENTOSUS WITH SEGMENTAL VITILIGO

To the Editor

Nevus depigmentosus (ND) is a rare, congenital, non-familial stable quasidermatomal leucoderma. Vitiligo is a common acquired heritable melanocytopenic disorder with a high incidence of associated disorders.[1]

A 13-year-old girl presented with two hypopigmented lesions. The first on the left lower back was an asymptomatic 5x4 cm macule with irregular borders, present since birth, static in size. The second lesion appeared 7 months ago in the right pectoral region extending from the anterior axillary fold to the lower part of the breast. The lesion was asymptomatic, 20x12 cm depigmented macule with trichrome appearance,

progressively increasing in size. Sensation over both the lesions was intact. No other skin or systemic abnormality could be detected. Histology of both lesions showed melanin pigmentation, dermal edema with mild perivascular lymphocytic infiltrate.

Nevus depigment is a rare and stable leucoderma, usually single with regular or serrated margins and tan to pale white in color. Histology may show either normal or reduced number of melanocytes due to the defect in the transfer of melanosomes.[2] Vitiligo is characterized by progressive, well circumscribed white macules, ocular abnormality, auto antibodies and various associated disorders. Histology shows the absence of melanocytes and melanin in the epidermis and lack of DOPA positive melanocytes.[2]

Cases of late - onset ND can be misdiagnosed as segmental vitiligo.[3] In a study of 67 patients with ND 60 had isolated type and 40% segmental type.[4]

Apart from clinical evaluation, staining with Fontana-Masson and S-100 protein can differentiate these two conditions. Our diagnosis was based mainly on clinical features.

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References

1. Mosher DB, Fitzpatrick TB, Ortonne J, et al. Disorders of pigmentation. In: Fitzpatrick TB, Eisen AZ. Wolf K, et al, eds. Dermatology in General Medicine. McGraw - Hill, New York 1987: 794-876.

2. Blechen SS. Disorder of skin colour. In : Champion RH, Burton JL, Burns DA, Breathnach SM, eds. Textbook of Dermatology. Blackwell Science, Oxford 1998: 1753-1815.

3. Kim YC, Kim SH, Park KC, et al. The study of vitiligo and nevus depigmentosus in children by clinical evaluation and DOPA staining. Kor J Dermatol 1998; 26: 544-553.

4. Lee HS, Chus YS, Hann SK. Nevus depigmentosus : Clinical features and histopathologic characteristics in 67 patients. J Am Acad Dermatol 1999; 40: 21-26.