mononuclear infiltrate, dilated dermal vessels with thickened walls and perivascular mononuclear infiltrate were observed. Lesions partially responded to 20 mg prednisolone OD for 2 months and later 10 mg OD for 4 months. Then he developed new bullae. Steroids were discontinued and final diagnosis of benign mucous membrane pemphigoid (BMMP) was established after excluding various genitoulcerative diseases. Circumcision had no benefit. Excellent response to dapsone 150 mg daily was observed as lesions healed completely in 42 days. Patient is now free of disease with dapsone 150 mg daily for 7½ months.

BMMP localized only to genitals is rare. We are reporting this rare case as it can mimic genitoulcerative disease and its differentiation from them is essential. Dapsone as observed by others,[1] has given excellent results in the present case.

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## SEBORRHOEIC KERATOSIS OF THE EXTERNAL GENITALIA

*To the Editor,*

Seborrhoeic keratosis is a common, benign condition of the skin. It does not usually appear before middle age.[1] Upper trunk and the face are the sites classically involved.[2] but lesions are also frequently seen on the extremities.[3] We report a case of seborrhoeic keratosis with lesions restricted to the skin on and around the genitalia.

A 32-year-old male patient noticed asymptomatic pigmented papular lesions on the dorsal aspect of the shaft of the penis 2 years back. Since then he developed similar new lesions on the scrotum and suprapubic area. There was no history of similar lesions elsewhere on the body. The patient was married and had two children. There was no family history of similar disease. He had no symptoms indicative of any systemic disease.

General physical and systemic examination revealed no abnormality. Cutaneous examination revealed multiple discrete, light brown flat papular lesions of 3 to 6 mm size on the dorsum of the shaft of the penis, scrotum and suprapubic area. All lesions had soft velvety surface and "stuck on" appearance. The perianal area, buttocks and rest of the body surface were free. The genital and oral mucosae were normal. Histopathological examination revealed marked acanthosis. No vacuolated cells were seen. Dermis was unremarkable.

Even though seborrhoeic keratosis can occur on any body site,[2] our patient seems to have an interesting presentation. Strict confinement of these lesions to skin on and around the genitalia and sparing of classical sites is unusual. Also the lesions presented at a relatively younger age. To the best of our information, seborrhoeic keratosis is not reported exclusively on and around the genitalia. Moreover, seborrhoeic keratosis in this location resembles verruca plana[4] more closely than at any other site and a high index of suspicion is essential for correct diagnosis.

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## ALOPECIA AREATA IN IDENTICAL TWINS

*To the Editor,*

Two 28-year-old, identical twins developed alopecia areata (AA) of the beard region simultaneously 2½ years ago. Both had a lesion each, one had involvement of the right cheek, while the other had the lesion on the left cheek. The use of potent topical corticosteroid (fluocinolone acetonide 0.1%) led to complete regrowth of hair in both patients within 3 months. One of them developed a new lesion in the same location 3 months later which responded to same treatment again. The other patient developed a new lesion on the same side of the face 2 years later, which had shown partial regrowth of hair after 2 months of treatment with topical fluocinolone acetonide 0.1% Cutaneous examination revealed patchy hair loss with no skin atrophy or any other surface changes.

Detailed history revealed no stress factor that could have contributed to the development of alopecia in these patients. Neither of them had history of any other autoimmune disease.

The development of AA has been observed in several members of the same family.[1] The incidence of family history of AA has been reported in upto 27% of the patients. There are only a few reports of AA occurring in identical twins.[2-4] The occurrence of AA in the members of the same family especially in the identical twins, supports the hypothesis that the patients of AA are genetically predisposed to developing this disease.

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## LEVAMISOLE IN VITILIGO OF EYELIDS

*To the Editor,*

The treatment of vitiligo has been disappointing and is indeed an arduous challenge for dermatologists. Although no therapeutic panacea exists, a variety of treatments benefit innumerable patients. Currently, the major therapeutic measures for vitiligo include psoralens and corticosteroids, topically and/or systemically, either singly or in various combinations.[1,2] Because melanocytes are indolent and slow responders to all current treatment modalities, treatment must be continued for 6 to 12 months for an optimal response.[3] We wish to share our experience with oral levamisole, an immunomodulator, and topical hydrocortisone butyrate cream used for treating vitiligo involving eyelids.

Since 1993 we have been treating our cases of vitiligo with oral levamisole 150 mg (50 mg for children) on two consecutive days every week combined with topical 0.1% hydrocortisone butyrate cream applied twice