LETTERS TO THE EDITOR

COINCIDENCE OF LICHEN PLANUS AND ALOPECIA AREATA

To the Editor,

Lichen planus has been associated with several disorders. With time it is becoming apparent that idiopathic lichen planus is being observed more and more in conjuction with diseases of altered or disturbed immunity. Such 'autoimmune' disease include alopecia areata, dermatomyositis, dermatitis herpetiformis, morphoea, myasthenia gravis, pemphigus foliaceous, pemphigus vulgaris, systemic sclerosis and vitiligo.[1]

A 18-year-male presented with generalised itchy skin lesions and circumscribed area of loss of hair over scalp since 1 month and 15 days respectively. There was no history of any exposure to STDs and recent medication for any illness. Cutaneous examination revealed erythematous and violaceous flat topped, polygonal papules which varied in size from pin point to a centimeter all over the body sparing palms, soles, face and scalp. Many papules demonstrated Wickham's striae. Koebner phenomenon was observed over the trunk. There was circumscribed patch of loss of hair measuring 4 x 3 cms over occipital area of the scalp without any signs of inflammation. Margin of the patch demonstrated 'Exclamation point' hairs. Examination of nail, mucous membranes and other systems did not reveal any abnormalities.

Routine haematological and urine examination findings were within normal limits. Blood VDRL was negative. Histopathological examination of the biopsied cutaneous papules confirmed the clinical impression of lichen planus.

The etiology of alopecia areata and lichen planus is not known with certainity. The clinical and laboratory evidences for AA and / or LP being an autommune disease is largely circumstantial. Co-existence of unrelated skin diseases is likely to be much less common. Co-existence of two disorders which possess a prominent immunological component in their pathogenesis may offer clues to their causation.

Coincidence of LP and AA has been scarcely reported in the literature.[2,3] The true nature of the association in the present case is difficult to determine, but seem to be casual rather than fortuitous.

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IDIOPATHIC FAMILIAL PIGMENTATION OF TONGUE- A NEW ENTITY

To the Editor,

Various causes of oral mucosal pigmentation have been mentioned in the literature. But isolated involvement of tongue only occurs in black hairy tongue[1], fixed drug

eruptions,[2,3] and pigmented nevi.[4] History and clinical features substantially differentiate one entity from the other. In none of them other family members are similarly affected. We herein report a case of isolated pigmentation over tongue in a young woman and her daughter.

A 36 year old female presented with asymtomatic hyperpigmented patches over tongue of 6 months' duration. There was no history of preceeding drug intake or sensation of swelling and numbness over the tongue. She was otherwise healthy with no history of weakness, diarrhoea or pain abdomen. On examination, multiple ill defined violaceous-black variably sized patches were noted over dorsum and lateral borders of tongue. There was no papillary hypertrophy, atrophy or erosion over the patches. No such similar patch was seen over any other part of oral mucosa, perioral areas, other mucosa and rest of the skin. Systemic examination failed to reveal any abnormality.

History and clinical features substantially rule out the possibilities of Addison's disease, Peutz-Jeghers' syndrome, lichen planus, fixed drug eruption and melanocytic nevi affecting tongue. Further enquiry revealed history of similar hyperpigmented patch over tongue in her 10 year old daughter. The duration in daughter was 1 year and as in mother other diagnoses were excluded. Thus a diagnosis of 'idiopathic familial hyperpigmentation of tongue' was made. None of the standard available texts on Dermatology mention about this peculiar familial pigmentation of the tongue. Our case could be a variant of racial mucosal hyperpigmentation[4] affecting the tongue selectively.

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PROTEUS SYNDROME

To the Editor,

Drs. Renu George and Mary Jacob's lapses in their case report titled 'Proteus Syndrome' published in the Ind J Dermatol Venereol Leprol 1993; 59 : 213-215 compel me to comment.

Proteus syndrome describes a disorder essentially of skeletal, hamartomatous and mesodermal malformations. As the patients exhibit tremendous morphologic variability, inclusion of atypical cases might vitiate the diagnosis. Hence to identify those features that are characteristic for this disease, major and minor criteria have been defined by various authors.

According to Samlaska[1] et al in their review of 34 patients, the following emerged as major clinical features i.e. hemihypertrophy (partial or complete), macrodactyly, subcutaneous tumours, plantar and palmar masses, exostoses (cranial and extremities), epidermal naevi (linear and whorled) and scoliosis.

The characteristic of the cutaneous anomalies seen are cerebroid, moccasin, brain-like or gyriform hyperplasia of the soles and/or less often, the palms. Histologically these