there was decrease of erythema and scaling. By the end of 4 weeks erythema disappeared, the plaque thickness diminished by 80%, no new lesions appeared and some lesions disappeared altogether. What is of interest is that all four patients had extensive plaques.

Extending this interesting observation further, we tried the same dose in 2 cases of lichen planus. After 2 weeks the lesions regressed by 50% . Some lesions disappeared and new ones did not appear. Both the patients had complete relief from itching.

We tried the same regimen in 4 cases of photodermatitis. After 4 weeks the lesions in all disappeared leaving residual pigmentation. All had complete freedom from itching.

The conclusion therefore is that vitamin D3, parenterally has got antipruritic, anti inflammatory and healing properties, on skin. It is also evident that vitamin D3 administered intramuscularly could be a good adjuvant to existing dermatological therapies.

The only theoretical objection for using vitamin D3, parenterally, could be hypercalcemia. However even after repeated checking in these patients serum calcium levels did not cross 11mg %.

We are reporting this observation, because we feel that parenteral vitamin D3 may prove an important medicine or an adjuvant in the treatment of many skin conditions.

Anandam Kuravi

Dept.of Skin & V.D.
AIMS, B.G. Nagar,
Karnataka-571 448.

Repigmentation of leukotrichia over vitiligo patches after punch grafting

To the Editor

Vitiligo patches are often associated with leukotrichia which usually remains as such even after complete repigmentation of the patches. While surgically treating vitiligo by punch grafting we incidentally observed repigmentation of leukotrichia in three patients. It was noticed between 10 to 16 weeks. The repigmentation started after 3 to 4 weeks of the perigraft pigment spread in all the three patients.

Vitiligo patches are often associated with leukotrichia which makes them relatively resistant to medical treatment. Even after successful repigmentation of a vitiligo patch with PUVA therapy, the leukotrichic hairs remain depigmented causing tremendous psychological trauma to the patient.[1] Of late punch grafting (PG) has revolutionised the treatment of stable and resistant vitiligo.[2] This surgical technique alone with PUVA has been found to repigment the vitiliginous skin quite effectively.[3,4] However, the issue of repigmentation of leukotrichia after PG has not been adequately addressed in the literature. Only recently split

thickness skin graft (STSG) has been found to repigment leukotrichia along with the repigmentation of vitiligo patch.[1,5]

After PG, the repigmentation of vitiligo patches occurs by the migration of melanin from the grafted skin in vitiliginous patch.[4] Melanin remains in the melanocyte reservoir at the basal cell layer or the follicles. Although melanin freely travels to the basal keratinocytes of the vitiliginous skin to the hair cortical cells the transfer is often found to be inadequate. As a result, in spite of complete repigmentation of vitiligo patches, often leukotrichia persists. The reason for the inadequate or incomplete melanin transfer is not known . Although the issue of repigmentation of vitiligo patch has been thoroughly discussed, the question of repigmentation of leukotrichia has not been adequately highlighted in the literature.

Once the successful repigmentation of leukotrichia occurs along with the vitiligo patch, the ultimate cosmetic outcome is unique. At present, we have taken up the study to probe further and evaluate the rate, degree and extent of repigmentation of leukotrichia after PG in patients with vitiligo.

We like to share our preliminary observation of repigmentation of leukotrichia over vitiligo patches after punch grafting.

Subrata Malakar Duncan Gleneagles
Sandipan Dhar Clinic & Research Centre,
Culcatta.

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