ISSN 0378-6323 May - June 2003

Indian Journal of Dermatology, Venereology & Leprology

EDITORIAL OFFICE
Dr. Uday Khopkar
Editor, IJDVL
2/7, Govt. Colony, Haji Ali,
Mumbai-400034.
E-mail: editor@ijdvl.com

PUBLISHED BY
Medknow Publications
12, Manisha Plaza,
M. N. Road, Kurla (W),
Mumbai-400070, India.
Phone: 91-22-25032970
Fax: 91-22-25032398
E-mail: publishing@medknow.com
Website: www.medknow.com

Manuscript submission
www.journalonweb.com/ijdvl

Cover design courtesy
Sudler & Hennessey

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CONTENTS (CONTD.)

The Indian Journal of Dermatology, Venereology and Leprology is a bimonthly publication of the Indian Association of Dermatologists, Venereologists and Leprologists and published by Medknow Publications.

The Journal is **indexed/listed** with Health and Wellness Research Center, Health Reference Center Academic, InfoTrac One File, Expanded Academic ASAP, NIWI, INIST, Uncover, JADE (Journal Article Database), IndMed, Indian Science Abstract's and PubList.

circumscribed allotrichia, and 4) Woolly hair nevus. Woolly hair in association with keratosis pilaris atrophicans and cataract,[1] keratosis pilaris and curling of eyelashes,[3] palmoplantar keratoderma and cardiac involvement[4] have been reported.

Inbreeding within the family, presence of woolly hair in children born consanguineously, and the absence of this abnormality in the parents of affected children, suggestive of autosomal recessive inheritance, were points favoring the diagnosis of familial woolly hair. However, there were no associated cutaneous or systemic abnormalities in them. Cases of familial woolly hair are rarely reported and its occurrence in three generations of a family is still rarer.

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Chronic pelvic inflammatory disease and melasma in women

Sir,

Melasma is a photosensitive dermatosis of the sun-exposed areas of the face, characterized by light or gray brown pigmentation.[1] The exact cause of this dermatosis is not known in a large proportion of cases. The majority of cases are considered to arise in pregnancy[2] and in patients on oral contraceptives.[3] The infrequency of melasma in post-menopausal women on oestrogen replacement therapy suggests that it alone is not the causative factor, although some of the patients on combination therapy with progesterone and oestrogen have been found to develop melasma.[1] Though, some of the patients of idiopathic melasma had mild ovarian dysfunction[4], plasma concentration of β-melanocytic-stimulating-hormone in these patients and those on oral contraceptives have been found to be normal.[4,5] Genetic factors, thyroid dysfunction, cosmetics, phototoxic and antiseizure drugs have been implicated as other etiological factors.[1] It was further shown by the study of Sawhney[6] at high altitudes, where the levels of UVB were 250% of those at sea level at mid noon, that melasma develops as a protective mechanism to either high levels of UVB or in those with photosensitive skin. Although it is seen predominantly in females, women even at high altitudes had a slightly higher incidence of melasma than men.[6] The question that needs to be answered is what makes the skin in females more photosensitive than in males. This study was thus designed to go into the details of the history and examination in cases of melasma in females.

A study was conducted in 127 cases of melasma in women who reported to the dermatology OPD from Jan to Mar 2003, to find out the possible underlying cause of this photosensitive disorder. The average age of the patients was 34.29 (range 19-65) years and the average duration of melasma was 45.72 (range 1-204) months. Seventy (55.12%) patients had received some form of topical therapy from a qualified dermatologist for an average duration of 4.28 (range 1-24) months with temporary/incomplete relief.

Seventy four (60.63%) patients of melasma had evidence of chronic pelvic inflammatory disease (PID), in 35 (27.56%) of them in association with Fitz-Hugh-Curtis (FHC) syndrome. The average age and duration of melasma in patients with FHC syndrome, PID alone and only melasma with no clinical evidence of PID was 37.06 (SD 8.49) and 48.77 (SD 57.56); 34.77 (SD 7.54) and 43.64 (SD 43.91); and 32.06 (SD 7.56) years and 38.79 (SD 38.00) months respectively. Patients with melasma with FHC syndrome were found to be significantly older ($p < 0.05$) than those with only melasma. Three (2.36%) had Reiter's syndrome, 2 (1.57%) conjugal melasma and 1 (0.79%) each had primary and secondary infertility.

Melasma was found in only 4 (3.15%) cases during pregnancy and in one with history suggestive of antepartum PID.

This study highlights that melasma in women is possibly due to photosensitivity in patients with chronic PID in a majority of cases. The association of melasma with pregnancy and oral contraceptives reported earlier was possibly due to increase proliferation of chlamydia during pregnancy due to lowered body immunity and milder nature of PID in those on oral contraceptives,[7] respectively.

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Comments on "Serological study for sexually transmitted diseases in patients attending STD clinics in Calcutta"

Sir,

It was interesting reading "Serological study for sexually transmitted diseases in patients attending STD clinics in Calcutta" published in Indian J Dermatol Venereol Leprol 2002; 68 275-278. We have some queries: comments for the authors to address.

What was the purpose of doing a qualitative VDRL test (which is more relevant in field conditions) in such a reputed institute of serology? A test with undiluted serum can result in false negativity because of the prozone phenomenon. Any titre cannot be considered significant (reactive). The VDRL test always has a standard cut off value for the uniform interpretation of results. However, the authors have not mentioned any such value in their article. In a developing country like India, various chronic infections can result in a false positive VDRL test in 1-3% of the patients. Further, a 'reactive' non-treponemal test indicates a present infection or a recently treated or untreated infection.[1] The result needs to be correlated with the medical history, examination and even with specific treponemal tests.

TPHA is a quantitative test reported in titre and so agglutination at a particular titre is more meaningful than mere agglutination. It is well known that a low degree of TPHA positivity will remain for years even in cases who have been adequately treated.[2] VDRL and TPHA tests indicate the same disease and adding them up falsely increases the total number of positive tests without any logical basis.

Serologic assays may be useful in detecting the prevalence of *Chlamydia trachomatis* infections of the genital tract in the community. Since 45-65% of patients may have IgG antibodies resulting from past infection, only a certain level of titre or demonstration of a four-fold rise in titre in a repeat sample is meaningful. Detection of IgM antibodies is more helpful in establishing acute chlamydia infections of the genital tract.[3] The present test report does not make us any wiser.

The results section is confusing; tabulating one or more serological tests in various combinations does not give any meaningful information. The article does not give us any idea about what the authors want to convey - single sample seropositivity without any cut off value?