cellulitis, and maculopapular plaques or nodules. Ecthyma gangrenosum is considered by many authors as pathognomic of Pesudomonas sepsis, though occurring in only 1.3% to 6% of patients with Pseudomonas bacteremia.[1] Although usually caused by P aeruginosa, it has been described in a case of P seudomonas cepacia endocarditis.[2] Lesions can occur anywhere but are usually found in the anogenital region, buttocks, extremeties, abdomen and axillae. In non-bacteremic ecthyma gangrenosum, the lesion is actually located at the site of entry of the organism into the skin; as opposed to classic ecthyma gangrenosum where the lesions represent a blood-borne matastatic seeding.[1]

This rare case of non-bacteremic ecthyma gangrenosum is consistent with earlier reports[1] having female predominance and better prognosis as compared to patients with Pseudomonas bacteremia, though occurring at a rare site.

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SILENT RENAL CARCINOMA PRESENTING AS CUTANEOUS METASTASIS

To the Editor,

Cutaneous metastasis of renal adenocarcinoma is rare.[1] A 70-year -old woman came with history of restricted movement of left upper arm of 3 months duration. A hard mass was noticed measuring 8x8 cm in left scapular region fixed to underlying muscles. Skin over the mass was pinchable and normal. Patient was anaemic, not jaundiced and there was no generalized lymphadenopathy. There was no organomegaly. Bowels and micturition were normal. Abdomen was scaphoid, soft, and no mass was palpable. Renal angles were free. Biopsy of left scapular mass revealed clear cell type of carcinomatous cells in sheets, and glandular pattern; separated by thin fibrous septa. The nuclei were centrally placed. Ultrasound of abdomen revealed 6.4x4.1 cm size hypoechoic mass arising from the lower pole of left kidney. General condition of the patient deteriorated and she became unfit for surgery. The diagnosis of silent renal cell carcinoma of left kidney with cutaneous metastasis was made.

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S V Ranga Reddy, Siva Kumar, G Baleswari,
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PAUCITY OF IMMUNE COMPLEXES IN SKIN LESIONS OF LICHEN PLANUS

To the Editor,

This is with reference to the article entitled "Paucity of immune complexes in skin lesions of lichen planus"[1] published recently in the Journal. We wish to share our experience on direct immunofluorescence (IMF) in lichen planus(LP). As reported by the authors we have also observed colloid bodies showing IgM, IgA, IgG and C3 deposits, however, in addition to the above we have consistently observed a