ragged fibrin band deposit along the dermoepidermal junction. The consistent presence of fibrin has been reported by other authors.[2,3] In addition, the authors have correlated the presence of positive IMF staining of colloid bodies with the age of the lesion. Although we have not correlated the presence of colloid bodies with the age of the lesion, we have detected its presence in almost all cases, except in the oral mucosa. Paucity of colloids in the oral mucosa has been reported.[4] To conclude, we feel that the presence of fibrin band should be looked for in LP.

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ERYTHROMELALGIA RESPONDING TO ASPIRIN

To the Editor,

A 14-year-old dumb girl was brought for the complaints of white soddening of the skin of both hands of 2 weeks duration. History revealed that the patient had for the past 3 months constantly immersed her hands in water. On examination, patient had candidal intertrigo of the webs of the fingers with keratolysis punctata of both hands. Skin over the hands was red and warm. Peripheral pulses were normally felt. Lower extremities were normal. There were no features to suggest any collagen vascular disease or peripheral occlusive vascular disease. Investigations revealed a normal RBC, platelet and WBC counts. ESR was normal. Rheumatoid factor and ANA were negative. A diagnosis of erythromelalgia was made and the patient was put on tab aspirin 1/2 tab per day and was simultaneously treated for candidal intertrigo. Response was dramatic. Patient stopped immersing her hands in water and the warmth and redness of the hands decreased considerably.

Erythromelalgia is a condition of painful red extremities in which a sensation of burning is associated with an increased temperature in the affected limb.[1] There are 3 types of erythromelalgia.[2] Our patient with bilateral involvement is likely to belong to type 2. This type is generally confined to the lower legs and is thought to share similarities with reflex sympathetic dystrophy. It usually does not respond to aspirin and may require sympathetic blockade for relief of symptoms. Aspirin is useful in treatment of type 1 in which there may be thrombocythaemia or other defects of platelet functions. It acts presumably by preventing platelet aggregation.[3] This type is generally seen in persons past their middle age.

It may be worthwhile trying aspirin in all cases of erythromelalgia as many patients irrespective of the type get considerable relief. Regular follow up of our patient is essential as erythromelalgia may be a presenting and premonitory symptom, often by several years. of myeloproliferative disorders like polycythaemia vera and thrombocythaemia.

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DIAGNOSTIC VALUE OF HYPOMELANOTIC MACULES OF TUBEROUS SCLEROSIS

To the Editor,

Hypomelanotic macules of tuberous sclerosis are the earliest manifestation of disease, usually present in 80% of affected infants at birth or within two years of life.[1-3] Though at times barely discernible these can be made prominent by Wood's light.[4] When frank depigmentation is present these are usually mistaken for vitiligo or naevus depigmentosus by unwary.

We recently observed two such patients misdiagnosed and treated as vitiligo and naevus depigmentosus respectively. One patient was 60-year-old male having two ash-leaf macules over legs and a shagreen patch over back without any history of epilepsy or mental retardation. Patient had these lesions undiagnosed since childhood and was recently treated with topical steroids with a diagnosis of vitiligo. The other patient was a 13-year-old girl with a single ash-leaf macule over face diagnosed as naevus depigmentosus with 6 years history of epilepsy treated with carbamazepine.

We realise that a small naevus depigmentosus with serrated margins can certainly be mistaken for ash-leaf macule if history of epilepsy and mental retardation, and lesions of angiofibromas and shagreen patch are not sought. This is especially true where ash-leaf macule is the sole manifestation of disease as a monosymptomatic form. In less defined lesions vitiligo is definitely a strong contender but non-progressive nature of ash-leaf macules and presence of melanocytes on histology can differentiate it from vitiligo. Besides being earliest, hypomelanotic macules do not require histologic confirmation if lesion is clinically obvious.[5] Three types of hypomelanotic macules are described and in order of frequency these are: polygonal or thumb print; ash-leaf or lance ovate; and confetti like.[1] Angiofibromas, the specific markers, are present in 70% of affected children but their appearance is delayed until 2-4 years of age.[1] Kwiatkowski et al have suggested that tuberous sclerosis is best diagnosed by experienced clinicians at specialized centres.[5] Importance of early diagnosis is especially a must because epilepsy in these patients if uncontrollable by drugs may be amenable to surgery at times.[4]

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