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LETTERS TO THE EDITOR

CUTANEOUS METASTASIS FROM CARCINOMA OF COLON

Cutaneous metastasis are relatively uncommon, their incidence has been assessed as 2 per cent (146 cases in 7196 necropsies). The most frequent primary tumours in men are carcinoma lung (24 per cent) and carcinoma of large intestine (19 per cent). Cutaneous metastasis indicate distant spread and provide a clue to the primary neoplasm.

We observed a case presenting as a skin nodule on the chest wall in a 58-year-old male with primary carcinoma of the colon. The patient had pain abdomen, weight loss and frequent rectal bleeding. Exploratory laparotomy revealed adenocarcinoma of colon and hemicolectomy was performed. Six weeks later, a small nodule, 2×3 cm size appeared on the anterior chest wall. This was umbilicated, firm, non-tender, painless and partially fixed to deeper structures. Histopathology of the nodule revealed an anaplastic adenocarcinoma. During follow-up, the hepatic involvement became evident in another two months. and the patient died a month later.

For diagnosis of the cutaneous metastasis, the macroscopic appearances of the nodule, histopathology and fine needle aspiration cytology are immensely useful and generally provide the clue to the primary neoplasm.

The chest wall and lower extremity are the common anatomical sites for metastatic lesions in visceral malignancies. Cutaneous metastasis may appear either early or late in the disease.

The general response of cutaneous metastasis to treatment is rather disappointing, it is usually related to treatment of the primary malignancy.

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TOPICAL SILVER SULPHADIAZINE CREAM IN HERPES ZOSTER

Topical 5 to 40% idoxuridine in DMSO is the only, somewhat effective, topical antiviral drug used in herpes zoster.[1] Recently, addition of silver sulphadiazine to the cell culture of varicella-zoster virus has been found to inactivate the viral infectivity at a concentration of 10 μg per ml at 37°C in 30 minutes time.[2] Clinical trials with 1% silver sulphadiazine cream applied four times a day over the skin lesions of herpes zoster revealed excellent results.[2] Prompted with this result, I tried the above drug in 15 patients. All patients were between 20 to 50 years of age. Ten cases were males and 5 females. The duration of illness varied between 2-5 days. Lower thoracic dermatomes were involved in 9 cases, lumber in 3 cases and cervical in 3 cases. One case had disseminated lesions all over the trunk on both sides along with involvement of the right cervical 3-4 dermatome. All the cases were advised to apply 1% silver sulphadiazine cream 6 hourly on the lesions. No other drug was given either orally or topically. Patients were watched every day.

The pain subsided in almost all cases in 24 to 48 hours. The vesicles and erythema subsided in most of the cases by 72 hours. In the patient with disseminated lesions, the lesions subsided in one week. All cases were followed up for 4 weeks. None of the cases had recurrence of the lesions or post-herpetic neuralgia (4 cases were above 40 years of age).

This clinical trial, although done in a small number of cases, and without a control group, does support the effectivity of 1% silver sulphadiazine in herpes zoster.[2] Further trials will be worth undertaking.

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IS SINGLE DOSE COTRIMOXAZOLE THERAPY EFFECTIVE IN CHANCROID

Cotrimoxazole is the drug of choice for chancroid, though some workers have reported a few cases of resistance.[1,2] Recently, some authors have reported that a single dose of cotrimoxazole containing 640 mg trimethoprim and 3200 mg sulphonamide is equally or more effective[3,4] than the daily cotrimoxazole. We have however, treated 6 male patients having clinically typical ulcers of chancroid with a single dose of 4 tablets of double strength cotrimoxazole (640 mg trimethoprim and 3200 mg sulphamethoxazole) and found a very disappointing response. All these patients had circular or oval, superficial,tender, non-indurated ulcers, 1 to 4 in number with ragged undermined edges. Two of these had unilateral non-fluctuating inguinal bubo, while the rest 4 did not have any lymphadenopathy. Dark ground examination for *Treponema pallidum* and tissue smears for Donovan bodies were negative in all. In one patient, a smear from the undermined edge of the ulcer showed *H. ducreyi*, while in others *H. ducreyi* was not demonstrable. Culture of *H. ducreyi* was not attempted. All patients were reviewed on the third and seventh day. None showed any improvement on the third day, while on the seventh day, one patient showed a 25% decrease in the size of the ulcers, 4 patients showed no change, while the ulcer had increased in size in the sixth patient. On the seventh day, therefore all the 6 patients were changed to the daily regime of cotrimoxazole giving 1 double strength tablet twice daily. By the end of the next week, 5 of these patients had already improved by 75%, while at the end of 2 weeks, there was complete healing. The sixth patient had to be given additional tetracycline 2 gm orally daily in four divided doses after 1 week as he had not improved with cotrimoxazole alone.

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SQUAMOUS CELL CARCINOMA ARISING FROM POROKERATOSIS OF MIBELLI

A 65-year-old man was seen for multiple keratotic patches with a central area of atrophy over the trunk and neck of 50 years duration. A clinical diagnosis of porokeratosis of Mibelli was made, and histopathology confirmed the diagnosis with the presence of a coronoid lamella. One of the lesions which was present on the patient's right forearm showed central ulceration. According to the patient, this lesion was originally similar to the other lesions and had ulcerated about 6 months ago. Biopsy of the ulcer showed squamous cell carcinoma showing hyperplasia and horn pearls and moderate pleomorphism.

Porokeratosis is a rare disorder of keratinization characterised by extending plaques of hyperkeratosis with central area of atrophy. Six types can be distinguished, namely, (1) classic porokeratosis (CP), (2) disseminated superficial actinic porokeratosis (DSAP), (3) porokeratosis palmaris et plantaris disseminata (PPPD), (4) porokeratosis punctata palmaris et plantaris (PPPP), (5) linear porokeratosis (LP) and (6) porokeratosis plantaris discreta (PPD).[1-6]

Development of squamous cell carcinoma or Bowen's disease within the lesions of porokeratosis has been reported earlier.[7] This case is reported to highlight the fact that early treatment could save the patient from developing an invasive malignancy.

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