HOW TO MAKE DERMATOLOGY-LEARNING EASY?

To the Editor

Dermatology is perhaps the toughest medical speciality to learn and more so for the beginners, post-graduates and general practitioners. The unfamiliar and difficult to pronounce dermatological terminologies, numerous synonyms and doundant technical jargons have made the learning of our speciality on ardous task. However, there are ways to make dermatology learning easy. Here's an example; To know the ARA criteria for diagnosing SLE, remember "MAD SON RAPHI".i.e,

M-malar rash
A-arthritis
D-discoid rash
S-serositis
O-oral ulcers
N-neurological manifestations
R-renal manifestations
A-antinuclear antibodies
P-photosensitivity
H-haematological manifestations
I-immunological

I am planning to write a book entitled "MAKING DERMATOLOGY-LEARNING EASY", compiling such mnemonics, cartoons /lucid diagrams and other such material. I am asking all dermatologists, and other physicians including postgraduates to send me any such material regarding skin diseases and their treatment which can help me in my endeavour. If desired, author of each item selected will be recognised in the book. I am hoping the finished book will be valuable for all its readers.

B C Ravikumar Department of Skin and STD
Kasturba Medical College
Manipal, Karnataka-576 119 (India).

SECONDARY SYPHILIS : AN UNUSUAL PRESENTATION

To the Editor

Secondary syphilis presents in many ways. Besides the common skin rashes, lymphadenitis, mucocutaneous lesions, sometimes alopecia also occurs. Atypical presentations are fairly common in secondary syphilis. Recently we came across such a presentation.

A 22-year-old unmarried girl presented with a two months history of asymptomatic, slowly progressive areas of hair loss of scalp. There was no history of intake of drugs, personal or family history of atopy. On examination, on right temporal and parietal areas, two well-defined, roughly square areas of hair loss about 4x2 cm were present. There were no skin changes over these areas. The hair loss was not complete, the remaining hairs being normal in texture and colour. No other area was involved and there were no nail changes. This hair loss raised suspicion and investigations were carried out. Her blood VDRL test was reactive in 1:16 ttitre and this was repeated two more times with the same results. Treponemal tests were not carried out because of non-availability. Retrospectively a detailed history and clinical examination for secondary syphilis was carried out. The patient denied any history of sexual contact and there was no other sign or symptom of secondary syphilis. The patient was given inj.benzathine penicillin 24 lacs IM once a week for total

three doses. Patient was reviewed after one month when the VDRL titre was 1:4 and about half of the area involved had regrowth of hairs. Follow-up at two month s showed complete and normal hair growth and the VDRL was non-reactive.

Secondary syphilis presenting only as alopecia is uncommon and definitely rare as there are no reports in literature.

This patient though denied a history of sexual contact, a possibility of sexual promiscuity can not be ruled out. Also in female patients a history of premarital or extramarital sexual exposure is not given easily. This patient could be in evolving phase of secondary syphilis and the other common feature like skin eruptions and lymphadenopathy might be following shortly. The hair loss in secondary syphilis is essentially nonscarring. It could be diffuse but commonly it is patchy alopecia sometimes giving a 'moth-eaten' appearance.[1,2] In this patient points against alopecia areata were non-oval rather square shape, ill defined border and incomplete hair loss. Significant VDRL titre which responded as expected with penicillin treatment and complete regrowth of hairs without any established treatment of alopecia areata confirmed secondary syphilis.

Alopecia areata is always a close differential diagnosis of secondary syphilis.[1,2]

This case also establishes the classical teaching in Dermatology, that secondary syphilis is an important differential diagnosis of nonscarring alopecia

Sanjay N Agarwal Department of Skin, STD and Leprosy
Dr. Panjabrao Deshmukh Memorial Medical College, Amravati-444 601, Maharashtra.

References

1) Adaora A, Hamilton HH, Holmes KK, et al. Sexually Transmitted Diseases : Companion Handbook, 2nd end, MC Graw -Hill Book Co, Singapore 1994; 66-72.

2) Willcox RR, Willcox JR. Venereology, Maruzen Asian Edition, Grant MC Intyre Ltd, London 1982 ; 184-189.

LORATADINE IN URTICARIA

To the Editor

Sir,

This is in response to the article 'A multicentric trial of Loratadine and cetirizine in urticaria by Jayakar Thomas, et al in Jan-Feb 1998 issue of your journal.

I liked to share my following observations and comments about their study.

1. In case selection they have used the term chronic urticaria. It is not clear is it same as chronic idiopathic urticaria. If not so are base line investigations sufficient to rule out all the underlying cause?.[1]

2. Regarding material and methods:

a. There is no mention of effects of Loratadine and cetirizine on the total duration of urticaria.

b. There is no patient's subjective evaluation scores and its correlation with efficacy of the drugs.

c. What had happened after 5th visit evaluation? Did it relapse? If so in how many of them?

3. One of the important parameters of antihistamine evaluation is assessment of cognitive and psychomotor impairment. No mention of it?.[2]

4. The authors claim that very little data available comparing loratadine and cetirizine in urticaria is ill founded. There are enough data available in the literature regarding the superiority of cetirizine over loratadine in contarary to the huge list of claims made by the authors depending on their single study. It is also a well accepted fact that