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## PEG - 200 WITH 12% SALICYLIC ACID OINTMENT IN PITYRIASIS AMIANTACEA

*To the Editor,*

A 40-year-old woman presented with scaling over the scalp and non-cicatricial alopecia for 2 years. She had been treated with various topical preparations such as betamethasone-salicylic acid ointment and selenium sulphide shampoo without much relief. Examination revealed masses of yellowish scales adherent to the scalp. KOH preparation for fungus was negative. A diagnosis of pityriasis amiantacea was made, and a sample of the scales was tested for solubility in the following organic solvents : absolute alcohol, acetone, ether, isopropyl alcohol, liquid paraffin, olive oil and polyethylene glycol (PEG-200). The scales were found to be most soluble in PEG-200, and the patient was advised topical application of PEG-200 with 12% salicylic acid and a tar-containing shampoo. At the time of review a month later, she was asymptomatic with minimal scaling on examination. No changes in hair texture were noticed.

Pityriasis amiantacea is a disease of the hair follicles manifested by thick asbestos-like laminated scales on the scalp.[1] Topical application of oil of Cade ointment or a tar/salicylic acid ointment has been recommended to eliminate the abundant scales.[2] Our experience leads us to suggest that topical application of PEG-200 with 12% salicylic acid is effective in treatment of pityriasis amiantacea.

*Anis Shah, SD Shenoi, CR Srinivas*
*Manipal*

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## CIPROFLOXACIN-INDUCED BULLOUS FIXED DRUG ERUPTION

*To the Editor,*

Ciprofloxacin is in use since 1986.[1] Due to its potent activity against both gram positive and gram negative organisms, excellent tissue penetration, good results in skin and soft tissue infections and twice a day dosage schedule; ciprofloxacin remains the most popular antibacterial among the dermatologists. However, adverse reactions like rashes and photosensitivity may occur. A single case of fixed drug eruption (FDE) due to ciprofloxacin has been reported earlier in a Japanese patient.[1] A novel case of bullous FDE is reported in an Indian patient.

A 25-year-old pharmacist was first seen in early May 1995 with a brownish-black circular patch with a central bulla measuring 1.25 cm by 1 cm in diameter and an erythematous halo on the dorsum of his right hand. He had earlier developed pharyngitis and took ciprofloxacin 500mg twice daily on his own. On the 5th day he developed erythema on his right forearm and hand which subsequently turned dark with a central bulla.

At this juncture he consulted our clinic. Patient was prescribed local steroid (Elocon; mometasone furoate 0.1%) once a day for 3 weeks.

Provocation test done later, using 125 mg oral ciprofloxacin, produced erythematous hallow around the previous pigmented patches. Patch test with ciprofloxacin was not performed.

Ciprofloxacin is a well tolerated drug. Side effects reported are nausea, abdominal discomfort, headache and dizziness.[2] Cutaneous rashes such as photosensitivity has been reported.[3]

Antibiotics, sulfonamides and their derivatives and antiinfective agents causing FDE are common.[1,4] Nonetheless, the newer quinolones producing FDE have not yet been reported except very few cases with ofloxacin[5] and a single case with ciprofloxacin only from Japan.[1] This case indicates that due to extensive use of ciprofloxacin in more than 56 countries other similar cases may come to light in future.

*Sumit Kumar Bose*
*New Delhi*

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# KYRLE'S DISEASE

*To the Editor,*

Kyrle's disease is a rare disorder of keratinization. It usually presents as multiple hyperkeratotic follicular and parafollicular papules with a central keratotic plug. The cause of disease is not known but it may be associated with diabetes, chronic renal failure and hepatic dysfunction.[1,2]

A 23-year-old man presented with slowly progressive mildly pruritic, painless, discrete polygonal, symmetrical, hyperkeratotic papules of 0.5 cm to 1.0 cm size, on the extensors of upper limbs, lower limbs and on buttocks. In the centre of papules a cone shaped keratotic plug was present which was readily removed with the help of curette. Routine examinations of blood, urine and stool were within normal limits. Patient was not having diabetes mellitus, renal failure or hepatic dysfunction. The clinical diagnosis of Kyrle's disease was made which was subsequently confirmed by the histopathological examination by presence of hyperkeratosis and parakeratosis of epidermis and a keratinous mass seen penetrating the follicular wall at places with dermal infiltrate predominantly of lymphocytes.

It is thought that metabolic disorders associated with Kyrle's disease are somehow responsible for development of abnormal keratinization and connective tissue changes,[3] but the actual mechanism may be different as in our case the Kyrle's disease was seen in otherwise healthy adult male.

*G Kalla, Dilip Kachhawa*
*Archana M Goyal, DR Mathur*
*Jodhpur*

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