# INFLAMMATORY LINEAR VERRUCOUS EPIDERMAL NEVUS AND SPINAL ANOMALY

To the Editor:

Inflammatory linear verrucous epidermal nevus (ILVEN) is a rather uncommon dermatosis that is unilateral, localized, pruritic, and usually refractory to treatment. It has an early age of onset and may be associated with underlying neurological disorders. ILVEN has also been reported in association with skeletal abnormalities.[1]

A 5-year-old girl presented with a pruritic linear verrucous rash on her right arm, extending from her right shoulder along the full length of the upper arm. The lesion was present since 2 months of age, and showed areas of excoriation. She gave a history of inability to walk, and repeatedly fell while attempting to do the same. A clinical examination revealed bilateral pes cavus and a sacral tuft of hair overlying a bony defect at the level of the first to the third lumbar vertebrae. MRI of the spine revealed a diastomatomyelia. A skin biopsy showed a psoriasiform histopathology with a chronic inflammatory infiltrate in the dermis consistent with the diagnosis of ILVEN. The patient underwent surgery for the correction of her diastomatomyelia.

Patients with epidermal nevi are at a significant risk of having other abnormalities[2] and warrant detailed clinical assessment. This case highlights the importance of including ILVEN as a component of the epidermal nevus syndrome.

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# DAPSONE SYNDROME IN PURE NEURITIC HANSEN'S DISEASE

To the Editor:

A 35-year-old lady presented with history of high grade fever, chills and skin rashes of one week duration. History revealed irregular treatment with dapsone and rifampicin for the past 2-3 months for recurrent bulla on the left middle finger.

On examination patient was febrile with maculopapular eruption, mild edema of the face and limbs. Tender generalised lymphadenopathy and tender, hepatomegaly without icterus were noticed. She had a non healing ulcer over the left middle finger. Wasting of interossei and hypothenar muscles were obvious. Ulnar nerve was thickened and tender on the left side with impairment of sensation over the medial half of the palm.

Patient had anemia with Hb 7.5 gms %. Bile salts, bile pigments and renal function tests were normal. A diagnosis of pure neuritic Hansen's disease with dapsone

syndrome was made and dapsone was stopped. Systemic steroids reduced the signs and symptoms. Five days later dapsone accidentally given to the patient by the junior doctor, resulted in flare up of skin lesions, fever and lymphadenopathy. Patient recovered fully with systemic steroid which was tapered gradually. Clofazimine and rifampicin were given for six months. Patient did not have any lesions and the bulla failed to reappear even after six months of follow up.

Dapsone syndrome is a type of hypersensitivity to dapsone which occurs after 4-6 weeks of therapy, the exact mechanism of which is not known.[1] The incidence is reported to be rare and declining.[2] It is reported in the treatment of Hansen's disease (PB and MB) and other dermatoses where dapsone is used.[3] This case is of interest because it is rare and still rarer in pure neuritic Hansen's disease. Also the therapy of Hansen's disease following dapsone syndrome with only clofazimine and rifampicin in this case is note worthy.

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## GENERALIZED AND BULLOUS LICHEN PLANUS TREATED SUCCESSFULLY WITH ORAL MINI-PULSE THERAPY

To the Editor:

A 28-year-old man presented with one month's history of multiple itchy, erythematous and violaceous papules on the trunk, knees and extremities. The lesions first appeared on the right foot and spread rapidly to involve the other areas within the next two weeks. In the next one week large non-haemorrhagic bullae appeared within the coalescing papules on the dorsum of both feet. There was no history of constitutional symptoms, diabetes mellitus, tuberculosis or intake of any drugs prior to onset of lesions. At the time of presentation, the patient was receiving antihistamines, emollients and prednisolone 20mg orally daily for two weeks without any relief. Cutaneous examination revealed multiple diffusely scattered violaceous to erythematous flat-topped 0.5-1.0 cm papular lesions on the abdomen, chest, neck, back, buttocks, legs, arms, hands, feet and face. At places the lesions were coalescing to form plaques. He had clear fluid-filled bullae of 2-3 cm size on the dorsum of both feet in the areas of coalesced papular lesions. The buccal mucosa had bluish hyperpigmented plaques with white lacy streaks at the margins. Bluish-white irregular plaques were present also on the dorsum of the tongue. Glans penis had a few superficial erosions. The scalp, nails, palms and soles were normal. Examination of other systems was unremarkable.

On investigations, the haemogram, fasting and post-prandial blood sugar, biochemical tests for liver and renal functions and chest X-ray were within normal limits. Biopsy from a papular lesion near the bullae from the right foot revealed hypergranulosis, band-like infiltrate of lymphocytes in close proximity to the basal layer of epidermis with degeneration of basal cells and subepidermal cleft at several places. Few Civatte bodies were also seen.