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HIV SEROPOSITIVITY IN TRUCK-DRIVERS

To the Editor,

Truck drivers are one category of high risk group for getting HIV infection due to their occupational travel. So an attempt was made to study the extent of problem of seropositivity in this high risk group.

Three hundred and three truck drivers passing from Pune-Ahmednagar, Maharashtra State highway were contacted in December 93, were interrogated, clinically examined and also their blood samples were taken for examination to know the HIV status among this high risk group. 282 sera could be tested for ELISA. Those positive for ELISA were also tested for western blot test. Sixteen were positive for ELISA as well as western blot test. While remaining 250 sera were negative for both the tests. HIV positivity rate was 5.67%.

Among the 16 with both tests positive, 8 were unmarried and gave history of visiting prostitutes and not using condom. The age group was from 20 to 34 years. Mahajan et al[1] have studied truck drivers of Gurudaspur district of Punjab and the prevalence of HIV positivity among them was 7.27/1000. In the present study it is seven times more. Studies in Manipur have shown a high prevalence of STD and HIV in places where trucks traditionally halt.[2] ICMR has reported very high seropositivity rate of about 30% in commercial sex workers.[3]

Such a high risk group is needed to be given health education regarding AIDS and other sexually transmitted diseases with special reference to the role of condom in protecting both the partners.

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SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS

To the Editor,

A 35-year-old woman presented with itchy, slowly progressive, erythematous discoid plaques ranging from 1 cm to 4 cm in diameter present over left pinna, tip of nose and alae nasi, left cheek, upper chest, upper back and left forearm for the past 6 months.

Most of the lesions showed atrophic surface with depigmentation, coarse adherant scales and plugged follicular orifices, while the lesions on the upper back were annular with mild pigmentary changes and fine scaling. Scalp showed a non-scarring skin-coloured plaque, about 1cm x 4cm in size, with uneven surface and prominent follicular orifices. Tin-tack sign was positive.

Associated complaints were increased itching and redness over plaques on sun exposure, anorexia, on and off vertigo, persistent joint pain in elbows, wrists, knees and ankles, and cyanosis of fingers with swelling and pain on dipping in cool water, which got relieved on warming.

The following investigations revealed significant results: ESR 58 mm in 1st hour, 24 hour urinary protein 300 mg, RA factor

positive, anti-nuclear antibody and anti-DNA antibody positive (0.092 and 50.6 IU/ml, respectively). Histopathological report of a biopsy taken from an annular plaque was consistent with the diagnosis of lupus erythematosus.

Gilliam in 1977 added a clinically distinct subset, subacute cutaneous lupus erythematosus (SCLE), to the spectrum of lupus erythematosus.[1] About half of the patients with SCLE fulfill the ARA criteria for the diagnosis of systemic lupus erythematosus (SLE), as was the case with our patient. The characteristic clinical features of SCLE are: (a) The type of lesions which are either non-scarring papulosquamous or annular or polycyclic; (b) The distribution: the lesions are usually located above the waist and particularly around the neck, on the back and front of the trunk and on the outer aspects of the arm and dorsum of the hands.[2] SCLE may be divided into two sub-sets according to clinical features: a "papulosquamous or psoriasis-like variety" appearing as erythematous papillary lesions with a scaly surface and an "annular polycyclic variety" with peripherally expanding annular or polycyclic lesions. Sometimes both patterns are seen in the same patient but one is usually predominant.[3] Localized scarring discoid lupus erythematosus-like lesions are found in about 20% of SCLE patients.[3] Our patient had such lesions on the front of chest.

Diagnosis of SCLE is important because these patients have a better prognosis than those with SLE and need to be managed less aggressively.[4] The patient is being treated with photoprotection, topical augmented betamethasone dipropionate and non-steroidal anti-inflammatory drugs. She has responded well in about a month. The scaling and induration of the lesions have markedly subsided and joint pain has lessened. This appears to be the first case of SCLE reported from India.

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SUB-ACUTE CUTANEOUS LUPUS ERYTHEMATOSUS

To the Editor,

Sub-acute cutaneous lupus erythematosus (SCLE) constitutes about 10-15% of total lupus erythematosus (LE) cases.[1,2] A 62-year-old housewife presented with widespread psoriasiform lesions of 7 days duration which appeared on back of shoulders, extensor surfaces of the arms, back above the waistline, V area of the upper chest and on extensor surfaces of legs in chronological order. The early lesions were slightly scaly erythematous papules. In the loin the lesions coalesced to form psoriasiform plaque. She had palatal ulcer and some degree of nonscarring frontal alopecia. The patient had suffered from fever (99-100° F) and pain in shoulders and neck for the last 5