SHIELD AS TOPICAL OINTMENT IN HERPES ZOSTER

To the Editor

It was really interesting to read the letter from Dr. Yogesh Agarwal published in our journal, July - Aug 97.

I would like to share our experience. We have been using lignocaine (5%) ointment routinely in treatment of herpes zoster cases for initial few days.[1] We avoid combination product keeping in mind the secondary infection and ACD[2] which steroid can precipitate. We also keep in mind to withdraw it as soon as possible so that the patient doesn't keep on using it for post herpetic neuralgia and we land up with another problem of ACD to lignocaine which it is known to cause.[3]

Sumit Kar
Dept of Skin and V.D, MG Institute of
Medical Sciences, Sevagram

References

1. The Practical Prescriber : Golwalla AF, 1990 (6th Ed) ; 52.

2. Wilkinson JD, Shaw S. Contact Dermatitis : Allergic, In : Textbook of Dermatology : Edited by R H Champion, J L Burton, A Burns, S M Briathnach, Blackwell Science Ltd. Oxford (6th Ed) 1998 ; 783.

3. Mark JG, Belsito DX, Leo VAD, et al. North American Control Dermatitis Group patch test results for detection of delayed type hypersensitivity to topical allergens, J Am Acad Dermatol 1998;911.

PUNCH GRAFTING IN VITILIGO

To the Editor

This is in reference to the article "punch grafting in vitiligo : Refinements and case selection" by Subodh Kumar Singh (IJDVL 1997, 63 :296 -300).

I want to add certain points in this regard.

1. The introductory sentence itself is somewhat confusing where it refers to the "complete disappearance of pigmentary cells in the basal layer of dermis and perifollicular epidermis, clearly there is a mix -up between "dermis" and "epidermis" .

2. The author has only included focal and segmental vitiligo in his study. Inclusion of other types of cutaneous achromia (eg. Vitiligo vulgaris, piebaldism, post-burn depigmentation etc.) could have made the study more broad based.

3. Duration of the disease varied from 1 to 19 years in the study but no mention was made about the period of disease stability. Before taking the operating option the clinician must ensure that the disease is inactive (i.e. the existing patches are not increasing in size, there is no new patch, and there is no Koebner phenomenon). In case of slightest doubt test grafting can be done.[1]

4. 2.5 -3mm punches were used in the study. When smaller punches are available use of larger punches could have been avoided easily. Falabella found 3 mm and even 2mm grafts more visible and scars more noticeable as compared to 1mm grafts.[2] He concluded that larger grafts left cobble stone appearance and smaller grafts are incapable of spreading favourable perigraft pigment spread. So he settled for a size in between, i.e., 1-2 mm.[2]

5. We have noticed in our studies that 2 mm punches can be used both in the donor and the recipient areas without any problem.[3, 4]

6. The chance of contact sensitisation to framycetin could be avoided by using sterile paraffin gauze.