DM infestation is hardly ever seen in Punjab and therefore diagnosis was missed earlier. Awareness is essential as it can be completely cured with specific medicines. Other drugs used are nitridazole(25mg daily for 10 days) and thiabendazole(5mg/kg for 3 days).[3]

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Metastatic cutaneous adenocarcinoma

To the Editor

A 60-year-old male presented with an asymptomatic erythematous lesion over right side of the forehead of one month duration. Patient was apparently healthy except for moderate degree of prostatism for last 2-3 years. On examination, a firm indurated plaque of 3x4cms size was present over right forehead involving right eye brow without any ulceration or eczematization. There was softening of the underlying bones of the forehead and orbit on the right side. X-ray of the skull showed large osteolytic lesion involving frontal bones and roof and lateral wall of the orbit on the right side just beneath the plaque lesion. Biopsy from the lesion showed poorly differentiated adenocarcinoma where cell of origin could not be ascertained. A thorough search with good clinical examination was done to locate primary site of adenocarcinoma. Skeletal survey of long bones and spine did not reveal any osteolytic lesions. A complete blood count, urine analysis, hepatic and renal function, serum acid phosphatase and x- ray chest were normal. A fine needle aspiration cytology from the prostate did not reveal any malignant focus. On learning about the diagnosis of cancer, the patient left for alternative system of medicine to seek cure and was lost to follow-up.

The skin is involved by metastases in 3-4% of malignant tumors. Most frequent sites of primary tumour being breast, stomach, lung, uterus, large intestine, kidney, prostate glands, ovary, liver and bones.[1] Lesions of cutaneous metastases are usually erythematous than normal skin and with marked induration resembling an inflammatory lesion. Cutaneous metastasis is usually a late and bad prognostic event.[2,3] Reingold reported a series in which survival time was not more than 3 months on the average from the time of diagnosis of cutaneous deposits.[4] It is likely that in present patient skin was involved secondary to the bone metastases as the cutaneous lesion was overlying the bone involved. Because

of the undifferentiated nature of the metastases and unwillingness of patient to continue treatment, the primary site of malignancy could not be ascertained. But it is likely that these metastases could have arisen from prostrate because bone involvement in prostatic carcinoma is not uncommon.

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Koebner response in psoriasis

To the Editor

In 1872, Dr. Heinrich Koebner spoke on the cause of psoriasis, presenting a case in which, 5 or 6 years after the appearance of an isolated plaque of psoriasis, various traumatic events in remote parts of the body (excoriation from horseback riding, suppuration from lymphadenitis, horse bite, and tattoos), evoked outbreaks of psoriasis in the patient at exactly the same site, in the shape of the injured skin.[1] This phenomenon is known as the isomorphic or Koebner response to injury.

Koebner believed that the skin of a patient with psoriasis has a peculiar predisposition to injury that may remain latent for many years. At variable intervals, local irritation will result in psoriaisis.[2] Patients with Koebner response are a "unique group who have distinctive epidermal or dermal response. Koebner response may be a marker for a subset of psoriatic patients. For these patients injury is a pathway to psoriasis. This pathway may result in an early onset or in an early flare of psoriasis.[3]

Psoriatic lesions have appeared following trauma due to gunshot wounds, lacerations, operative incisions, tattooing, burns, ultraviolet light, primary irritation from chrysarobin, iodine application, or in association with infections and furunculosis, pressure from wrist watch and even grasping of a pencil. There is usually a 10 to 14 day latent period between injury and development of lesions, but onset may be delayed as long as 2 years.[4]

My first case is a 30-year-old electrician who developed an isolated psoriatic plaque exactly at the site of electric shock injury on the tip of right middle finger approximately 3 weeks after trauma. The lesions subsequently spread to involve both palms and soles, and developed into a classical case of palmo-plantar psoriasis within 3 months of electric shock injury.