smear for tubercle bacilli was negative. Lowenstein-Jenson medium did not yield growth after 6 weeks. Mantoux test was positive with a reading of 15 mm after 48 hours. The VDRL and HIV tests were non-reactive.

The hematoxylin and eosin stained section of skin lesion revealed the formation of tuberculoid granuloma composed of epithelioid cells, mononuclear cells, langhans and foreign body giant cells located in the dermis. There was not much of caseation necrosis. Secondary epidermal change in the form of hyperkeratosis and acanthosis of the epidermis were present. Acid fast bacilli could not be demonstrated.

Short course treatment regime comprising of INH 300 mg, rifampicin 450 mg and ethambutol 800 mg daily was given for 8 weeks. Favourable response was recorded by regression in the induration as well as hyperkeratosis. The treatment with INH and rifampicin was continued after 2 months, for another 7 months.

The bilateral disposition of lupus vulgaris over the buttocks leaving normal intervening skin in the natal cleft is unusual. This probably resulted from auto-inoculation of the lesion from one buttock to the other.

Devinder M Thappa, B R Garg,
C Ratnakar
Pondicherry

OCCURRENCE OF SQUAMOUS CELL CARCINOMA AND MULTIPLE CUTANEOUS HORNS IN POROKERATOSIS

To the Editor,

A 75-year-old male presented with multiple atrophic plaques over the upper limbs, trunk and lower limbs of 4 years duration. The lesion in the upper limbs extended from the forearm to the arm. The plaque in the lower limbs involved the knee, ankle and thigh regions. The plaques showed central atrophy with a raised peripheral keratotic edge. Using a hand lens, a furrow could clearly be made out in the edge. Multiple small atrophic lesions with a keratotic edge could also be seen in the trunk. A depressed plaque was also made out in the tongue. GHair, nail and teeth were normal. The plaque over the right forearm showed an ulcerated growth (Fig.1). The plaque in the left lower limb showed in its upper border, a large hyperkeratotic horny projection about 4 cm in height and having a diameter of about 3 cm in the base (Fig 2). A similar projection was seen in the lower end of the same plaque. routine investigations were normal. Biopsy of the plaque in the left forearm from the raised edge showed the typical features of porokeratosis. Another biopsy was done from the ulcerated area on the right forearm. This revealed a squamous cell carcinoma (SCC). a wide excision of the SCC was done. Follow up over a period of 1½ years showed no recurrence. Biopsy of the cutaneous horns showed no evidence of any malignant degeneration.

This case, an elderly male who has manifest porokeratosis for several decades presents a unique combination of both cutaneous horns and SCC over different plaques of porokeratosis. Malignant degeneration is more common in the giant, linear and plaque types of porokeratosis. Many mechanisms have been suggested for the malignant change in these lesions. One is the presence of an instability in the short arm of chromosome 3 as seen in cultured

fibroblast studies.[1] Immunological factors may also contribute. Earli erreports have documented the occurrence of cutaneous horns in porokeratotic lesions.[2] The clinical significance of these lesions is that they can represent forerunners of malignant change. We report this case to emphasize the need for careful surveillance of all lesions of porokeratosis as they represent potential premalignant lesions.

P Devakar Yesudian, S G S Krishnan, M Jayaraman, V R Janaki, Patrick Yesudian

Madras

References

1. Scappaticci S, Lambiasi S, Orechia G. Clonal chromosome abnormalities with preferential involvement of chromosome 3 in patients with porokeratosis of Mibelli. Cancer Genet Cytogenet 1989; 43: 89-94.
2. Riyaz N, Nair LV. Multiple cutaneous horns arising from porokeratosis. Ind J Dermatol Venereol Leprol 1994; 60: 150-2.