

nent skin markings over fingers, rough skin, orangish discolouration of finger pulps and nails following use of henna. Two had warts and callosities. However none had active hand dermatitis on examination. Hence patch tests were not done.

We feel that hand dermatitis is not a common problem in our beauticians due to their awareness and use of protective measures. In our study only one had past history of itching with vesicles in the absence of protection. Dryness of skin can be attributed to frequent washing of hands with soap and water. Perming lotions, hair dyes and bleaching creams contain irritant substances which can cause contact dermatitis. Use of gloves when handling these agents is imperative.

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MUPIROCIN IN FOLLICULITIS CRURIS PUSTULOSA ET ATROPHICANS

To The Editor,

Chronic folliculitis of the legs is known to dermatologists since many years and was referred to by different names including folliculitis decalvans, epilating folliculitis of glabrous skin etc.¹ This chronic folliculitis has been consistently shown to be due to *Staphylococcus aureus*. Different modalities including antiseptics, dyes,¹ tincture iodine,² cotrimoxazole, dapsone and PUVA therapy³ have

been used with varying results. Mupirocin is a new topical antibiotic reported to be as effective as systemic antibiotics, especially against *Staphylococcus aureus*.⁴ Hence we tried topical mupirocin 2% ointment in the management of these patients.

Three patients with chronic folliculitis were treated. All three of them were young adults in the group of 20-30 years. Two of them had the disease for 3-4 years and the third patient had it for a long duration of 10 years. One was a gardener by occupation, second was a peon in an office and third patient was a manual labourer. None of them was involved in cutting sugarcane or fishing, the occupation which have been implicated as etiological factors.⁵

Patients were advised to use topical mupirocin ointment twice daily after washing and were followed at weekly intervals. Response was impressive with 50% improvement in 7 days and complete clearing in 4 weeks. The first patient had no recurrence over 6 months follow up, whereas other patients have just completed the treatment one month back and are on follow-up.

Mupirocin, is an antibiotic with a unique mode of action. It acts as a competitive inhibitor of the enzyme isoleucyl transfer RNA synthetase and competes with the amino acid isoleucine for binding sites and thus inhibits protein synthesis. Its MIC against *Staphylococcus aureus* is 0.25 mcg/ml and it has a very low sensitizing potential and is devoid of serious side effects. Because of the unique mode of action, it is unlikely to lead to cross resistance with other systemically used antibiotics. In our

experience mupirocin has been very effective in the treatment of folliculitis cruris pustulosa et atrophicans. A larger controlled trial is needed for assessing its full potential and a longer follow up to determine recurrences.

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REPIGMENTATION OF LEUKOTRICHIA OVER VITILIGO PATCHES AFTER PUNCH GRAFTING

To the Editor

Vitiligo patches are often associated with leukotrichia which usually remains as such even after complete repigmentation of the patches. While surgically treating vitiligo by punch grafting we incidentally observed repigmentation of leukotrichia in three patients. It was noticed between 10 to 16 weeks. The repigmentation started after 3 to 4 weeks of the perigraft pigment spread in all the three patients.

Vitiligo patches are often associated with leukotrichia which make them relatively resistant to medical treatment. Even after successful repigmentation of a vitiligo patch with PUVA therapy, the leukotrichic hairs remain depigmented causing tremendous psychological trauma to the patients.¹ Of late punch grafting (PG) has revolutionised the treatment of stable and resistant vitiligo.² This surgical technique along with PUVA has been found to repigment the vitiliginous skin quite effectively.^{3,4} However, the issue of repigmentation of leukotrichia after PG has not been adequately addressed in the literature. Only recently split thickness skin graft (STSG) has been found to repigment leukotrichia along with the repigmentation of vitiligo patch.^{1,5}

After PG, the repigmentation of vitiligo patches occurs by the migration of melanin from the grafted skin in vitiliginous patch.⁴ Melanin remains in the melanocyte reservoir at the basal cell layer or the hair follicles. Although melanin freely travels to the basal keratinocytes of the vitiliginous skin to the hair cortical cells the transfer is often found to be inadequate. As a result in spite of complete repigmentation of vitiligo patches, often leukotrichia persists. The reason for the inadequate or incomplete melanin transfer is not known. Although the issue of repigmentation of vitiligo patch has been thoroughly discussed, the question of repigmentation of leukotrichia has not been adequately highlighted in the literature.

Once the successful repigmentation of leukotrichia occurs along with the vitiligo