described are (a) male sex, (b) younger age of onset, (c) sudden onset, (d) low grade fever, (e) sparing of flexures, and (f) lack of annular or circinate lesions.

R Rajagopal

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DERMATOLOGISTS' VIEW OF WHO MDT REGIMEN

To the Editor

I read with great interest the letter written by Dr R Ganapati, Leprologist, Bombay in our journal 1995 Vol.61, titled "co-ordination in Leprosy elimination programme." He has highlighted the fact of Government of India in taking effective steps under NLEP to make MDT available to almost all identifiable patients in most part of our country. He has also mentioned that he is surprised to note that inspite of low endemicity reported (by Govt.), the dermatologists are encountering a large number of leprosy patients.

As a practising Dermatologist and as the leader of many skin camps conducted by Lion Dr TV Venkatesan Memorial Foundation and sponsored by Rotary, Lions International, etc., I would like to bring the following details.

In my consultations as well as in the Skin camps I have noticed lot of leprosy cases who have been administered MDT (mostly fixed duration). There the treatment is discontinued as per the guidelines of WHO. After a period of surveillence such cases have to resort to private treatment from dermatologists because they are not completely cured of the disease or got relapse. Hence the increase in the number of leprosy cases seen by dermatologists as stated by Dr Ganapati in his letter. Therefore I would like to mention that the treatment of leprosy cases should be continued till the complete inactivity of the disease by the Government agencies duly bringing it to the notice of WHO.

V Harshan
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ERYTHEMA ANNULARE CENTRIFUGUM RESPONDING TO DAPSONE

To the Editor,

A 47-year-old male reported with a mildly pruritic skin lesion over the right forearm of 2 weeks' duration. The lesion was an annular erythematous plaque, of about 2.5 cm in diameter, and had a raised border. Topical antifungals, and later topical steroids were given. After an initial response to topical clobetasol propionate 0.05%, the lesion started progressing and extending. New lesions with an annular configuration started appearing proximal to the initial lesion. The plaque was then biopsied and subjected to histopathological examination. The epidermis showed irregular atrophy with spongiosis and focal parakeratosis. There was a sharply demarcated perivascular infiltrate of lymphocytes in the dermis. Based on the histopathological diagnosis of Erythema Annulare Centrifugum, topical steroids (betamethasone dipropionate 0.05%) was continued, but with no effect. The lesions

started involving the upper arm and shoulder. At this juncture, dapsone, 100 mg twice daily, was introduced, alongwith topical application of an emollient cream. The patient responded dramatically with almost complete resolution of all the lesions, including the primary one, within a week. Dapsone was then continued, in the same dose for another week, and then tapered to 100 mg once daily, and stopped after a fortnight. After complete resolution, the patient has not had any recurrence of lesions.

Daspone has found useful in a wide variety of inflammatory cutaneous disorders viz., vesiculobullous disorders, vasculitides, pustular psoriasis, and the like.[1] However, despite reports of its efficacy in Erythema elevatum diutinum,[2] and Granuloma annulare,[3] its use in the treatment of Erythema Annulare Centrifugum has not been documented. Dapsone is purported to have a suppressor action on polymorphonuclear leucocytes, inhibits mitogen stimulated lymphocyte transformation, and also has effects on membrane associated phospholipid metabolism, lysosomal enzymes, and tissue proteinases, but the specific mechanism of action of dapsone, and how it affects a wide variety of dermatological diseases, are unknown.

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Cochin

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JARISCH-HERXHEIMER REACTION IN EARLY SYPHILIS

To the Editor,

This is with reference to letter to the editor 'Febrile herxheimer reaction' (Ind J Dermatol Venereol Leprol 1995; 61: 180-1). We wish to share our experience of a similar study whereupon clinical, haematological and histological features of J-H reaction were studied in 50 cases of early syphilis after penicillin therapy.[1] J-H reaction was observed in 40% of patients with primary syphilis, 70% and 33% of patients with secondary and early latent syphilis respectively. The febrile response followed a uniform temporal pattern with height of fever as chief variable being highest in patients with early manifestations of secondary syphilis. Polymorphonuclear leukocytosis and raised ESR were detected in 37% and 88% of cases with J-H reaction. Subepidermal oedema, dilated blood vessels with endothelial prominence and perivascular round cell infiltration were the consistent histological features of cutaneous reaction.

Gurcharan Singh, Y P Jalpota

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