from reaching out to other areas of the body.

However, when the patient firmly denies any conscious rubbing in the presence of real or, more important, imagined disfigurement, the diagnosis of dysmorpho-phobia has to be ruled out. In dysmorpho-phobia, a condition of disturbed psychological body image, the face and nose represent the indivisual's main areas of concern of his/her body image. These patients may present with psychogenic itching, burning, imagined facial hair and imagined distortions and the sequelae thereof. An attempt must be made to differentiate these patients into two groups-one, psychologically deluded and the other, anxiously and neurotrically preoccupied with their skin.[2] This condition has been considered as ominous because it is often a harbinger of schizophrenia.[3] This again underlines the importance of exercising extra caution while dealing with females presenting with facial symptoms. Meanwhile it will no doubt be fruitful to have psychological assessment carried out on all cases of keratotic papules on chin.

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SEBACBOUS NAEVUS WITH CHRONIC LEG ULCERS

To the Editor,

Sebaceous naevi (SN) can be found in about 0.3% of all neonates.[1] SN is usually located on the scalp or face at birth as linear, oval or round hairless plaque. Usually SN are single but may be multiple or extensive. Extensive SN show associated CNS, eye or skeletal deformities.[2] Mental retardation and epilepsy may be associated.[3] SN and verrucous epidermal naevi are very closely related and may represent variants.[4] Histopathologically, SN in children show cords of undifferentiated hair cells simulating embryonic hair follicles, some hairs have dilated keratin filled infundibula with multiple buds of undifferentiated cells. At puberty, SN show large number of mature or nearly mature sebaceous glands with papillomatous hyperplasia of overlying epidermis with changes as seen in children.[5] Malignant change can superimpose secondarily in middle age or even earlier.

A 22-year-male was admitted with chronic venous leg ulcers since 2 years. In addition he had 2 plaques on the chin and right cheek since early childhood with rapid progression at puberty. He had epilepsy at the age of 5 which was treated. He had low intelligence and bilateral iridocyclitis. Bigger plaque on chin was 11 X 7.5 cm, firm, non-tender, mobile in certain drections, pinkish-brownish with well defined margins right side and ill defined on left and lower side. Its surface was smooth, velvetty, thrown into folds, sparse hairs were present in the centre of plaque with alopecia on either side. Similar 1.5 x 1.0 cm plaque was seen on the outer side of right angle of mouth. Systemic examination and routine investigations were normal. Histopathology revealed multiple mature sebaceous glands with peripheral mononuclear infiltration, giant cells and papillomatous hyperplasia of overlying epidermis.

SN are reported to be common type of naevi but we see them rarely in our area. The present case was a type of SN and association of chronic leg ulcers may be coincidental.

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OUT BREAK OF SCABIES FROM A CASE OF NORWEGIAN SCABIES

To the Editor,

Patients of Norwegian scabies (NS) have high mite population and present with hyperkeratotic crusted papules.[1] NS occurs more in patients of autoimmune disorders due to associated immunosuppression.[2] Although scabies occurs in pandemics, localized epidemics in chronic health care facilities are known.[3] One such localized epidemic was treated with 5% permethrin and other with 1% Lindane.[4,5]

A 36-years-female was admitted as a case of systemic lupus erythematosis (SLE), erythroderma and NS. She had SLE since 5 years which was controlled with 20-40 mg prednisolone daily. 6 months prior to admission she and her family developed scabies which was treated in all except the patient where it progressed to infected crusted papules, nodules, pustules, ulcers & erythroderma i.e. NS. Lesions were more in webspaces, around nipples and groins etc. SLE also worsened as she developed photosensitivity, dyspnoea on exertion, severe anaemia, oedema feet, loss of weight and appetite. She had intense pruritus with nocturnal itching and insomnia. Diffuse hair loss, residual lupus hair with scaling and crusting of scalp were seen. Generalised lymphadenopathy was present. Liver was enlarged by 3 fingers, smooth, soft and slightly tender. 2 bed sores, of 3 cm and 4.5 cm in diameter with yellow granulation were seen on buttocks. She was restless and at times aggressive since 15 days.

HB was 4.0 gm %. TLC was 10,700. DLC was P71, L22, E5, M2. ESR was 30 mm. TSP were 5.5 gm %, albumin 2.6 gm % and globulins 2.9 gm %. Urine sugar was 0.5%. FBS was 60 mg %. Scrapings revealed Sarcoptes scabei.

Strangely, within 10-30 days of her admission, all junior residents, patient's attendents, other female ward patients, nursing staff and later thier families developed common type of scabies. Patient was treated with 10% crotamiton till ulcers healed and erythroderma was controlled. Repeated applications of 1% lindane cured NS in 3 months. All her clothes and bed linen were boiled daily. All others suffering in this localized epidemic were treated with 1% lindane.