postulated.[3,4] We report a patient who developed oral lichen planus following dental fillings with amalgam containing mercury. A 19-year-old male presented with reticulate bluish white lesions on both buccal mucosa of 2 years duration, in relation to teeth filled with amalgam 4 years ago. Patch testing with dental series (Chemotech AB, Sweden) using Van der Bend chambers showed a positive reaction to elemental mercury (1%) in petrolatum.

Histopathology showed features of LP with basal cell degeneration and band of inflammatory infiltrate in upper dermis. A standard direct immunofluorescence showed a ragged fibrin basement membrane zone band. Fibrin band on immunofluorescence has been reported in LP.[5]

The amalgam fillings were replaced with an inert posterior composite. Two months later the lesions had subsided and patient is asymptomatic.

A diagnosis of oral LP was made based on clinical features, histopathology and immunofluorescence. As the patient was sensitive to mercury and as the lesions appeared following the amalgam filling and subsided following its removal we further feel that in this case mercury in the dental amalgam could have been the precipitating or provoking factor. In a case of oral LP with dental fillings we therefore recommend patch testing with relevant metals, removal of amalgam filling if found positive and replacement with an alternative material.

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TOPICAL TRIAMCINOLONE ACETONIDE IN AN INDIGENOUS ORABASE IN ORAL LICHEN PLANUS

To the Editor,

Oral lichen planus (LP) affects upto 1% of the population.[1] It is about eight times more common than cutaneous LP.[1] The treatment of oral LP is a therapeutic problem. Topical steroids in a conventional cream base do not adhere to the oral mucosa for a sufficiently long time to cause therapeutic action. Use of intralesional corticosteroids, though effective, has the drawback of pain at injection sites and risk of secondary infection. Other therapeutic modalities include oral vitamin A,[2] topical cyclosporine (100 mg/ ml) in the form of an oral rinse[3] and temarotene,[4] a new oral retinoid. Orabase[5] (a gel of carboxymethylcellulose, pectin and gelatin), available commercially in the West, is an ideal vehicle for topical corticosteroids for oral mucosa. We have developed an indigenous orabase and used it as a vehicle for triamcinolone acetonide (40 mg/ml). This was prepared by adding Vi syneral syrup (30 ml) and Moisol (hydroxypropyl cellulose) eye drops (10 ml). Triamcinolone acetonide (40 mg/ml)

was added in this base. The preparation adheres to the oral mucosa for a long time and can be applied twice daily.

We treated 20 patients with oral LP of varying severity with this preparation applied topically twice a day. A remarkable improvement in 16 (80%) patients was noticed after 4 weeks of use. Ten out of 20 (50%) patients showed complete clearance after 3 to 4 months. They are on regular follow up to detect any signs of recurrence. No side effects have been noticed. We propose topical triamcinolone acetonide in indigenous orabase as the treatment of choice due to its cost effectiveness, safety and excellent therapeutic efficacy.

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ALOPECIA AREATA AND XEROSIS IN DOWN'S SYNDROME

To the Editor,

A 4 years 9 months old girl reported with the history of repeated respiratory tract infection. On examination she had typical Mongol face and congenital heart disease (VSD) with left to right shunt. Skin examination showed dry skin all over the body with loss of hair on four places of scalp. Diagnosis of Down's syndrome was established by clinical finding and karyotyping chromosomal analysis. Alopecia areata occurs in Down's syndrome in older children.[1] In our patient alopecia areata started when child was 11 months old .

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AIDS RELATED KAPOSI'S SARCOMA-LIKE LESION

To the Editor,

Kaposi's sarcoma (KS) is the commonest neoplasm in persons infected with HIV. India has the largest number (68%) of HIV infected individuals among the countries of South-East Asia. The major mode of transmission of HIV in India is through sex (75%)[1] but in Manipur the major route is through injection (52%).[2] HIV associated KS is thought to be rare in this part of the World but this may not remain so in future. No proved case of KS has been reported so far from Manipur.

We have suspected a 22-year-old male suffering from AIDS related KS. The patient presented with occasional cough, haemoptysis, fever, loss of appetite and darkening of complexion for approximately 6 months. Macules and papules started to appear 2 months later in the trunk and gradually became generalized. They were reddish in colour to start with and later became dark brown, there was no associated pain or itching. There was also a history of difficulty in swallowing food for 1 month. He slowly