positive, anti-nuclear antibody and anti-DNA antibody positive (0.092 and 50.6 IU/ml, respectively). Histopathological report of a biopsy taken from an annular plaque was consistent with the diagnosis of lupus erythematosus.

Gilliam in 1977 added a clinically distinct subset, subacute cutaneous lupus erythematosus (SCLE), to the spectrum of lupus erythematosus.[1] About half of the patients with SCLE fulfill the ARA criteria for the diagnosis of systemic lupus erythematosus (SLE), as was the case with our patient. The characteristic clinical features of SCLE are: (a) The type of lesions which are either non-scarring papulosquamous or annular or polycyclic; (b) The distribution: the lesions are usually located above the waist and particularly around the neck, on the back and front of the trunk and on the outer aspects of the arm and dorsum of the hands.[2] SCLE may be divided into two sub-sets according to clinical features: a "papulosquamous or psoriasis-like variety" appearing as erythematous papillary lesions with a scaly surface and an "annular polycyclic variety" with peripherally expanding annular or polycyclic lesions. Sometimes both patterns are seen in the same patient but one is usually predominant.[3] Localized scarring discoid lupus erythematosus-like lesions are found in about 20% of SCLE patients.[3] Our patient had such lesions on the front of chest.

Diagnosis of SCLE is important because these patients have a better prognosis than those with SLE and need to be managed less aggressively.[4] The patient is being treated with photoprotection, topical augmented betamethasone dipropionate and non-steroidal anti-inflammatory drugs. She has responded well in about a month. The scaling and induration of the lesions have markedly subsided and joint pain has lessened. This appears to be the first case of SCLE reported from India.

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SUB-ACUTE CUTANEOUS LUPUS ERYTHEMATOSUS

To the Editor,

Sub-acute cutaneous lupus erythematosus (SCLE) constitutes about 10-15% of total lupus erythematosus (LE) cases.[1,2] A 62-year-old housewife presented with widespread psoriasiform lesions of 7 days duration which appeared on back of shoulders, extensor surfaces of the arms, back above the waistline, V area of the upper chest and on extensor surfaces of legs in chronological order. The early lesions were slightly scaly erythematous papules. In the loin the lesions coalesced to form psoriasiform plaque. She had palatal ulcer and some degree of nonscarring frontal alopecia. The patient had suffered from fever (99-100° F) and pain in shoulders and neck for the last 5

months. Nails revealed no abnormality, past history revealed that the patient was admitted in BS Medical College & Hospital, Bankura for sulphonamide-induced Stevens - Johnson syndrome (SJS). At that time patient was treated with steroids, associated IHD with CCF was also diagnosed and managed with digoxin and dytide (thiazide) drug for one week.

Routine laboratory investigations showed - Hb 4.8gm%; TLC 10,000/cumm; DLC N 45%, L 40%, E 15%; ESR - 75mm in 1st hour; platelet count 2,60,000/cumm; LE cell (-)ve; ANF (+)ve; VDRL (-)ve; Urine : epithelial Cells - a few, pus cell 3-5/HPF, RBC nil, cast nil; chest X-ray slightly enlarged cardiac shadow in transverse diameter with ventricular predominance but no lung parenchymal or hilar abnormality; ECG - IHD with left ventricular strain pattern. Skin biopsy from the representative lesion was compatible with SCLE. The patient was put on low dose prednisolone (30mg/day) and chloroquine phosphate (500mg/day). After 2 weeks of therapy she responded well.

The patients of SCLE are usually young and middle aged white women of 15 to 40 years.[3] It is very uncommon in blacks of either sex. The cutaneous lesions of SCLE are differentiated from the generalised DLE on clinical grounds alone.[1] In contrast with marked systemic illness in systemic LE, SCLE patients frequently have mild systemic illness and no serious CNS, renal or systemic vascular involvement; yet half of the patients fulfill the ARA criteria for SLE.[2] Thin, easily detachable scales, psoriasiform lesions in striking distribution pattern with positive ANF, anaemia, raised ESR, musculoskeletal complaints, fever and compatible skin biopsy report helped in the diagnosis.

However, in this case it is yet to be established whether such a short term therapy with sulfonamide or thiazide could be a precipitating factor of SCLE.

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CONNECTIVE TISSUE NAEVUS - NAEVUS ELASTICUS

To the Editor,

Juvenile elastoma (naevus elasticus) is a connective tissue naevus of elastin that may occur as a sporadic isoloated lesion or multiple lesions as the Buschke-Ollendorf syndrome.[1,2] We, herewith, report a case of juvenile elastoma in a 21-year-old male for its rarity and clinical interest.

A 21-year-old male noticed an asymptomatic gradually increasing swelling over the midline of back for last 5 years. There was no history of seizures. No family history of similar lesions was forthcoming. Cutaneous examination revealed a single, oval, soft to firm, 3x4 cm subcutaneous swelling with dermal infiltration at T12 level in the midline