pattern,as first described by Sharp, et al.[1-3] In contrast, 'overlap syndrome' is a vague term describing presence of clinical and /or laboratory features of two or more distinct connective tissue disorders in the same patient. Eventually the patients with 'overlap syndrome' tend to evolve into a classical picture of a single connective tissue disease.

Therefore,with the information reported regarding the case , the authors are not in a position to correctly label the reported patient as a case of MCTD, as the essential criteria for the diagnosis (vide- supra) are not fulfilled. Further, a diagnosis of polymyositis appears to have been made empirically on the basis of 'generalised decrease in muscle power' (which by itself is unusual in PM/DM as it causes a weakness predominantly of girdle muscles). Patient's estimation of muscle enzymes (CPK, aldolase, SGOT, LDH), electromyography and muscle biopsy which are integral ARA criteria for diagnosis of polymyositis are conspicuously missing. Pulmonary symptoms (productive cough and blood stained sputum) in presence of a normal X-ray of chest have strangly been explained by authors as a feature of scleroderma. Systemic sclerosis gives rise to a 'restrictive lung disease with progressive dyspnoea. Productive cough is uncommon and haemoptysis is rare. Further, hepatosplenomegaly, as reported in the patient is not a feature either of polymyositis or systemic sclerosis. In our opinion, on basis of available information, this patient is likely to be suffering from systemic lupus erythematosus (SLE) as joint pains, fever, myositis, pulmonary symptoms and hepatosplenomegaly are all well documented features of SLE. We advise the author to get immunological investigations (ANA and to DNA) done which might help clinch the diagonsis.

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ROLE OF BLOOD TRANSFUSION IN THE MANAGEMENT OF STEVENS-JOHNSON SYNDROME (SJS) AND TOXIC EPIDERMAL NECROLYSIS (TEN)

To the Editor

Stevens - Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are the two common emergencies encountered in day to day dermatology practice.[1,2] In spite of taking all antiseptic and aseptic measures and providing barrier nursing, the mortality rate in such cases may be as high as 50%.[1-3] Early institution of systemic corticosteroid (s) may be helpful.[5,6] However, often many patients report to the dermatologists quite late in the disease when, except

barrier nursing, fluid and electolyte monitoring, there is not much to offer to them. At this stage institution of blood transfusion significantly alters the progress of the disease and modifies its outcome by curtailing the morbidity and reducing the mortality rate.

Over the last 2 1/2 years, I have treated 10 patients with SJS and 8 patients with TEN.In all these patients there was 60%-80% involvement of skin indicating a poor prognosis . In 8 patients (3 SJS, 5 TEN), systemic corticosteroid was given as they were brought within 3-4 days of development of skin lesion (S). In the rest 10 patients, corticosteroid was withheld since they were brought quite late . In all the 18 patients 2-3 units of blood was transfused after proper grouping and cross matching. Only two patients died , while16 recovered without any complication(s).

The efficacy of blood transfusion in cases of SJS and TEN is probaly multimodal. First, the toxic metabolites of the incriminating drug viz, arene oxides get diluted by haemotransfusion resulting in its reduced action on target tissue e.g, skin and mucous membranes. Cytotoxic T cells and autoantibodies could also be getting diluted in similar ways. Secondly, freshly transfused blood supplies immunoglobulins to combat infections. Moreover,transfused blood prevents hypovolaemia resulting from the loss of blood from skin surfaces. It also supplies nutrients and electrolytes essential for the tissue perfusion and thereby indirectly help in the function of cardiovascular and renal system . Transfusion of blood, thus combats many complications and final outcome of the disease.

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EFFECT OF PARENTERAL VITAMIN D3 IN SKIN DISEASES

To the Editor

Taking the clue from the topical use of vitamin D3 derivatives in psoriasis and its efficacy, we in AIMS,.G. Nager,tried vitamin D3 parenterally in psoriasis. For the experimentation we used Arachitol of Duphar Company, 3 lakh international units intramuscularly every week for 4 weeks and we found substantial improvement in 4 patients. In first week itself,