LETTERS TO THE EDITOR

ALTA DEPIGMENTATION

Alta is a pink-coloured liquid used on the feet by women in this part of the country during religious festival days. It is applied mainly on the sides of the feet, while single rounded spots are also made on the dorsa of the feet. Some women apply it frequently whenever they fast or perform a Pooja. A case of alta depigmentation is being reported.

A 22-year-old woman presented with depigmentation on the sides and dorsa of both feet for the past four months. She had developed redness and scaling at the site, prior to the loss of pigment. She had been using alta for the last 4-5 years. Patch testing with alta showed a dermatitic reaction after 48 hours. When reviewed after 10 days, the patch test site still showed erythema. Depigmentation developed at the site five weeks after the patch test. Depigmentation was still persisting when the patient was last seen 2 months after the loss of pigment at the patch test site. Patch tests with alta in 13 controls did not show a positive reaction.

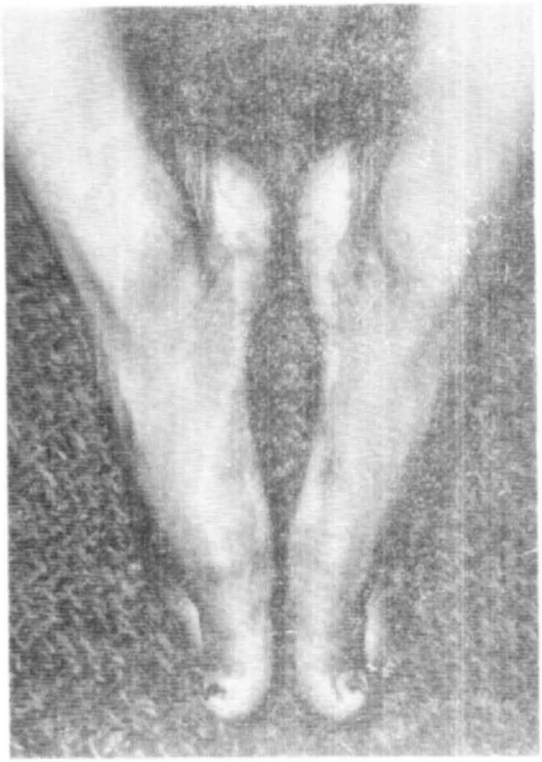

Fig. 1. Depigmentation on the sides of the feet.

The depigmentation in this case seems to be secondary to contact dermatitis. Contact depigmentation is known from rubber and plastic articles and bindis. Monobenzyl ether of hydroquinone, paratertiary butyl phenol and paratertiary butyl catechol are the most well known depigmenting agents.[1] As it was not feasible to get the analysis of the material done, it will be difficult to comment on the particular chemical responsible for the depigmentation in this patient. The case is of interest as such cases are very likely to be diagnosed as acral vitiligo.

Dr. A K Bajaj and
Dr. Rajeev Sharma

Department of Dermatology and Venereology,
MLN Medical College, Allahabad.

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1. Calnan CD : Occupational leucoderma from alkyl phenols. Proc Roy Soc Med, 1973; 66 : 258-260.

ABOUT THE JOURNAL

Please accept my sincere congratulations on your exhalted position as Chief Editor of our official journal. It is a recognition of your professional proficiency and speaks for your personal efficiency and charm. As you know, I was only a managing editor and remained so far a decade.

Manifestations of your qualities of head and heart are already evident in the face-lift to the format of the journal as also classification of contents. Of course this is going to cost a good amount to the journal exchequer. That means you will have to exert to procure a sizeable number of ethical advertisements. Now since the journal is based in Delhi, you can do so easily as quite a number of drug companies are at hand in the capital. You will recall, I always maintained at our various conferences that the journal constitutes or should constitute and provide the financial resources for the various activities of the association.

In order that the journal should not lose its topical interest and other utilities, I would request you to pay attention to the following requirements.

(i) Printer's devils. For international competition it is necessary to do perfect proof reading. I was glad to note that the latest issue Sept-Oct, 1984 contained very few errors. I did not receive July-Aug, 1984 issue.

(ii) Please be regular and punctual in production and despatch of the journal to various categories.

(iii) Instructions to Authors should be published in each issue. It should be a Must to acknowledge Indian work on the subject in References and Bibliography, otherwise the article should be returned for necessary correction. Please find herein enclosed a copy of instructions issued by Indian Journal of Medical Sciences of Bombay, now in 39th year and for which I am a referee.

(iv) Invite Guest Editorials as in Journal of Physicians of India.

(v) There is much room for improvement in reproduction of photographs, particularly of histopathology.

(vi) Case reports should not be published if not accompanied by the illustrative photographs.

(vii) Readers' participation. For this, encourage section on Letters to the Editor and a Correspondence Section.

(viii) You may introduce a division on Interesting, Odd and Rare Observations on any aspect of the speciality.

(ix) Historical Development. It will be a part contribution to research if this subject is developed either by one individual or separate ones on different sections of the triple speciality.

(x) Reports from State branches and Statistics Registry. I hope you realise the obvious advantages. You know we still don't have reliable statistics or incidence of even common diseases. So you may ask State Secretaries to send for publication, statistics regarding incidence of different diseases as published in the annual reports of all Medical Colleges, Hospitals, and such other reliable sources. Thus, an all India registry can be maintained in a classified way and the same may be supplied to W.H.O. publication division at Delhi.

(xi) Title Page. Please convey my congratulations to your wife for the attractive format of the journal, I would suggest a minor change. It may add to the beauty if the red ink is used for Title letters i.e. the caption of the journal viz : I.J.D.V.L., and I.A.D.V.L., as your wife advises.

This will be in keeping with the accentuated colour of the skin.

(xii) Finally, you may see if prizes, medals and scholarships can be instituted to encourage quality articles, letters, research etc.

I think this much is enough in the first encounter with you. I know I am giving unsolicited advice but you being an old and reliable friend, I make bold to do so and hope you will not mind all this and perhaps more to follow at a later date depending on the type of response from your side.

In the end I wish to convey my appreciation and thanks to your entire team for upgrading the journal in all respects in a short time in spite of your multifarious adventures including your T.V. Projection for your innovations on allergy masks.

Dr. T. K. Mehta

Vice-President & Chairman Executive Committee
The Bombay Social Hygiene Council
10, Indian Mercantile Mansion,
Room No. 2, Opp. Regal Cinema,
Bombay-400 039.

REPLY

Many thanks for your letter dated 27.5.85. I feel indebted to you for your kind encouraging words and the suggestions for improving the journal. Some of your suggestions are in fact already being carried out. As for example, (1) I am checking the proofs of the whole journal myself till the authors can take up this responsibility in a responsible manner. (2) We are doing our best to wipe off the delay in the production of the journal which occurred due to the process of transfer. But it may be reassuring to know, that even the May-June 1985 issue is already in the press. So as soon as the press is able to spare some extra time for us, the delay will be wiped off. (3) I am regularly approaching experts in various fields to contribute articles on Continuing Medical Education. The stress is on an uptodate review of the literature on the topic with a total information on the Indian studies. Anyone who can contribute such an article is welcome. (4) Some case reports or other papers which have not been adequately worked up, are included in the Letters to the Editor, but if the members do not send their comments on the published articles, the editor becomes helpless. Interesting or rare observations are also included in the Letters to the Editor. (5) The title page was designed by my 13-year-old daughter and not my wife. The design was liked by most people, though one does not expect absolute consensus. I will similarly, have opinion of others on your suggestion and take suitable decision. (6) I agree with you that reproduction of the photographs is still very poor in spite of the fact that I return or eliminate photographs which are of too poor quality. We do want to switch over to photo-set-printing, but finances are our main problem. It is becoming increasingly difficult do procure advertisements in spite of our best contacts. There are only two alternatives; either all dermatologists must agree to prescribe only those drugs which are advertised in the journal, or every member must obtain some donations from whatever agencies (even non-medical) are possible, for the journal. Please give it a thought and hlep us. (7) Instructions to the authors will be printed in the Jan-Feb issue of every year. When we have more funds, we can do it in every issue. No doubt, I spend a lot of time correcting the manuscripts or pleading with the authors to prepare their manuscripts according to the IJDVL pattern. There are hopeful signs, but some authors are still quite callous (or may be obstinate). I hope to become more strict with such authors in future, so that I can utilize my time more fruitfully. (8) Prizes, medals and scholarships are under active consideration, but we will need donors. I am actually planning a scholarship for training Indian dermatologists at Indian Institutions for the locally useful techniques, and not what most of our colleagues have been

doing with WHO and other similar scholarships. (9) Your idea of reporting the incidence of various diseases from various parts of the country is very good. In fact, similar data was published in the past under your editorship. It can be repeated, may be in a more organised manner. I do feel that we need to organise ourselves better. My experiment with the National Survey for Contact Dermatitis was very encouraging and I wish we repeat such experiments.

Overall, I am having very good support from my co-editors who are very efficient and equally enthusiastic, the members of the editorial board, and others who are helping us in various ways and I am sure that with continued co-operation, we can achieve our goals. We only need a little awakening, self confidence, hard work and co-operation.

Dr. J. S. Pasricha
Editor IJDVL

LICHEN PLANUS, HYPERTHYROIDISM AND PROPRANALOL

A 32-year-old female developed acute widespread lichen planus along with the early signs and symptoms of hyperthyroidism. A short course of systemic corticosteroid which she received recently from a local hospital, had no effect on the skin lesions. Detailed clinical examination and laboratory tests confirmed the diagnosis of hyperthyroidism. The skin lesions were histopathologically typical of lichen planus. To control the adrenergic manifestations of hyperthyroidism, the patient was given a course of propranalol 40 mg thrice a day for one month which resulted in a dramatic relief of pruritus and flattening of the skin lesions. Later, the case was treated in the medical ward with propranalol and neomercazol. Follow-up of the patient for 4 months did not show any evidence of relapse of skin lesions.

Association of acute lichen planus and hyperthyroidism may be fortuious. But complete lack of response to corticosteroid therapy is quite unusual. The fact that some cases of lichen planus are neurogenic in origin and hyperthyroidism is associated with pronounced adrenergic manifestations such as sweating, tremor and tachycardia, prompted us to try propranalol, a beta-adrenergic receptor blocker, in the present case. A dramatic relief of the signs and symptoms of lichen planus and subsidence of various adrenergic manifestations of hyperthyroidism followed propranalol therapy.

This observation of early cure of lichen planus after propranalol therapy in a patient with hyperthyroidism suggests that lichen planus may be due to a disorder (? hyperactivity) of the sympathetic part of the autonomic nervous system. Lichen planus had been reported in association with tumours of the suprarenals and tumours of the paravertebral localization pressing on the sympathetic pathways.[1] Increased incidence of hypertension in patients with lichen planus[1] and observation of proliferation of peripheral nerve tissue in early papules[2] also suggest that the autonomic nervous system may be taking an active part in the actiopathogenesis of lichen planus. Propranalol, a widely used and most popular beta blocker, is a relatively safe drug, though it is contra-indicated in patients with certain cardiac diseases, bronchial asthma, diabetes and psoriasis. This observation has made us try this drug in a few more patients with lichen planus. The early results are encouraging.

Dr. K. Pavithran

Dept of Skin & VD,
Medical College Hospital,
Kotayam-686 008, India.

References

1. Arndt KA : Lichen planus, in : Dermatology in General Medicine, Editors, Fitzpatrick TB, Eisen AZ, Wolff K et al : McGraw-Hill Book Company, New York, 1979; p 655-702.
2. Midana A and Ormea F : Modern views on aetiology and pathogenesis of lichen planus, Excerpta Med (Sec XIII) 1958; 12 : 3-5.