obtained in this case. The papules and nodules in present case did not fit at least clinically into any of the other skin diseases.

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WHY LESIONS OF MORPHOEA ARE OFTEN HYPERPIGMENTED?

To the Editor,

The lesions of morphoea are characterized by indurated areas of skin, which at first are faintly purplish or mauve in colour. After a few weeks or months, they lose their colour, especially in the central part and appear as thickened waxy ivory coloured areas with a characteristic lilac border.[1] In Indians with mostly type IV or type V skin colour, we rarely appreciate the purplish or mauve colour and lilac border in the lesions of morphoea. Instead, in most of our patients we observe mild hyperpigmentation over the morphoea plaques. In the standard text[1] these hyperpigmented patches are stated to be present at the very beginning of morphoea lesion(s) or at the site of resolving plaque(s). However, we see these patches mostly over the well developed plaques of morphoea. The pathomechanism of such hyperpigmentation has not been elucidated in the standard textbooks.[1,2]

We have been interested to look into this aspect and to find out the status of melanocyte and basal cell layer in the histopathological sections of morphoea lesions. On Fontana-Masson stained sections, we have found that there is increased melanocytic activity in the form of prominent melanocytes in the basal cell layer. It appears that there is increased melanin synthesis inside the melanocytes. There is no basal cell degeneration and melanin incontinence. The first author has been observing this histopathological phenomenon for the last 6 years.

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CLEARANCE OF PLAQUE PSORIASIS FOLLOWING IRRITATION DUE TO CALCIPOTRIOL

To the Editor,

A 9-year-old girl presented with extensive plaque psoriasis of 3 months duration. In view of inadequate response to topical coal tar and steroid therapy, calcipotriol (50 µg/g) was started. Patient developed irritant reaction to topical medicament within a