syndrome was made and dapsone was stopped. Systemic steroids reduced the signs and symptoms. Five days later dapsone accidentally given to the patient by the junior doctor, resulted in flare up of skin lesions, fever and lymphadenopathy. Patient recovered fully with systemic steroid which was tapered gradually. Clofazimine and rifampicin were given for six months. Patient did not have any lesions and the bulla failed to reappear even after six months of follow up.

Dapsone syndrome is a type of hypersensitivity to dapsone which occurs after 4-6 weeks of therapy, the exact mechanism of which is not known.[1] The incidence is reported to be rare and declining.[2] It is reported in the treatment of Hansen's disease (PB and MB) and other dermatoses where dapsone is used.[3] This case is of interest because it is rare and still rarer in pure neuritic Hansen's disease. Also the therapy of Hansen's disease following dapsone syndrome with only clofazimine and rifampicin in this case is note worthy.

Rajkumar V

From the Department of Dermatology, STD and Leprosy, SDU Medical College, Tamaka, Kolar-563 101.

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GENERALIZED AND BULLOUS LICHEN PLANUS TREATED SUCCESSFULLY WITH ORAL MINI-PULSE THERAPY

To the Editor:

A 28-year-old man presented with one month's history of multiple itchy, erythematous and violaceous papules on the trunk, knees and extremities. The lesions first appeared on the right foot and spread rapidly to involve the other areas within the next two weeks. In the next one week large non-haemorrhagic bullae appeared within the coalescing papules on the dorsum of both feet. There was no history of constitutional symptoms, diabetes mellitus, tuberculosis or intake of any drugs prior to onset of lesions. At the time of presentation, the patient was receiving antihistamines, emollients and prednisolone 20mg orally daily for two weeks without any relief. Cutaneous examination revealed multiple diffusely scattered violaceous to erythematous flat-topped 0.5-1.0 cm papular lesions on the abdomen, chest, neck, back, buttocks, legs, arms, hands, feet and face. At places the lesions were coalescing to form plaques. He had clear fluid-filled bullae of 2-3 cm size on the dorsum of both feet in the areas of coalesced papular lesions. The buccal mucosa had bluish hyperpigmented plaques with white lacy streaks at the margins. Bluish-white irregular plaques were present also on the dorsum of the tongue. Glans penis had a few superficial erosions. The scalp, nails, palms and soles were normal. Examination of other systems was unremarkable.

On investigations, the haemogram, fasting and post-prandial blood sugar, biochemical tests for liver and renal functions and chest X-ray were within normal limits. Biopsy from a papular lesion near the bullae from the right foot revealed hypergranulosis, band-like infiltrate of lymphocytes in close proximity to the basal layer of epidermis with degeneration of basal cells and subepidermal cleft at several places. Few Civatte bodies were also seen.

Direct immunofluorescence was negative. On the basis of clinical, histological and immuno- fluorescence findings a diagnosis of bullous lichen planus was made.

The patient was treated with oral mini-pulse therapy consisting of 5mg betamethasone given orally as a single daily dose on two consecutive days every week. In addition, betamethasone dipropionate 0.01% gel twice a day for topical application on the oral and genital lesions was also advised. Within two weeks fresh lesions had stopped appearing completely and older lesions started subsiding rapidly. The bullae subsided without any scarring. Oral mini-pulse was tapered in a step-wise manner reducing it by 0.5 mg every week and was completely stopped in the next 10 weeks. There were no side-effects of the therapy. The lesions have not relapsed during the 12 months follow-up.

Acute presentation with generalized involvement is uncommon in lichen planus.[1] Appearance of bullae is even rarer. This patient had a typical presentation and classical features of lichen planus. In bullous lichen planus, the blisters arise on or near the lesions of lichen planus. Histologically, a subepidermal bulla is associated with other changes of lichen planus and direct and indirect immunofluorescence is negative.[2] Bullous lichen planus differs from lichen planus pemphigoides where clinically the bullae appear on both involved as well as uninvolved skin[2] and histologically, a subepidermal bulla is seen without much evidence of lichen planus. In addition, direct immunofluorescence shows linear basement membrane zone deposition of IgG and C3 in the perilesional skin.[3,4] Corticosteroids as oral mini-pulse (OMP) have been found to be effective in some other corticosteroid responsive dermatoses.[5] The advantages of oral minipulse are its convenient dosage schedule, efficacy and insignificant side-effects. Our patient had complete remission with OMP after 10 weeks of treatment without having any side effects. Hence OMP can be used as an alternative to daily corticosteroids for the treatment of lichen planus safely and effectively.

Arun Joshi, Binod K Khaitan, Kaushal K Verma, *Manoj K Singh

Department of Dermatology and Venereology and Department of *Pathology, All India Institute of Medical Sciences, New Delhi-110029.

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