LETTERS TO THE EDITOR

Kyrle's disease and vitamin D resistant rickets in chronic renal failure

To the Editor:

Kyrle's disease is one of the perforating dermatoses and a rare chronic disorder of unknown aetiology. The pathogenic event in this condition is a disorder of epidermal keratinization. Clinically Kyrle's disease is characterized by hyperkeratotic para-follicular or follicular papules, with central cone shaped plug which can be removed easily, usually involving the extensor surface of extremities. Histopathology reveals a heavy keratotic, partly parakeratotic plug containing basophilic debris lying in an invagination of the epidermis.[1] Serveral authors have reported the association of Kyrle's disease with diabetes mellitus, renal failure, hyperlipidaemia, liver diseases, congestive cardiac failure with an infective process and with abnormal vitamin A metabolism.[2]

A 16-year-old male patient presented with asymptomatic hyperkeratotic parafollicular and follicular discrete papules with cone shaped removable central plug since four months. The lesions first appeared on the extensor aspect of thighs and upper extremities and gradually involved the buttocks, back and lower abdomen. The patient had abnormal presence of posterior urethral valves leading to bilateral hydronephrosis and chronic renal failure since the age of seven years. His blood urea and serum creatinine were raised throughout in all repeated investigations. Later on he developed vitamin D resistant rickets. His serum calcium was 7.26 mg% and serum phosphorus was 5.3 mg%. There was no family history of similar illness. Haemogram, blood sugar, liver function test, serum lipid profile, X-ray chest and ECG were within normal limits. X-rays of skeletal system showed characteristic changes of rickets. Histopathology of skin lesions was suggestive of Kyrle's disease.

So in this patient of chronic renal failure there was a simultaneous association of vitamin D resistant rickets and Kyrle's disease.

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Clinical and bacteriological study of pyoderma in Jodhpur-Western Rajasthan

To the Editor:

Pyogenic skin infection is one of the common conditions. The universal use of antibiotics has produced changes in bacterial flora of man and increased resistance by the micro-organism.[1] In a study conducted in our department on 200 patients with purulent skin infection, various predisposing factors along with organism causing pyoderma and their sensitivity to commonly used antibiotics were considered.

Diagnosis was made on clinical grounds and those patients who had not received any antibiotics in the past 15 days were taken in this study. Laboratory investigations included smear for Gram's staining, bacteriological cul-

ture, drug sensitivity test and identification of each isolate by standard biochemical tests.

The highest incidence was observed in first decadeof life 70(30%) followed by second decade 54(27%). More than 80% were of middle and lower income groups. Clinical analysis showed that Impetigo 58(27%) formed the largest clinical group followed by infectious eczematoid dermatitis 42(21%), furunculosis - 42(21%), folliculitis 32 (16%) secondary pyoderma 14 (7%), cellulitis 7(3.5%), ecthyma 4(2%) and carbuncle 2(1.0%)

In our study staphylococcus was isolated as a single organism in 90 (52.6%), followed by Bhaemolytic streptococci 27 (15.7%), mixed organism 26 (13%). Similar study conducted by others showed *Staphylococcus aureus* isolation from 68% of cases.[2]

Complications of pyoderma were id reaction 11 (5.5%) and urticaria 7(3.5%). Acute glomerulonephritis was found as a complication of B - haemolytic streptococcal infection in 1 (o.5%) patient. Similar observation reported streptococcal infection in 8 of the 9 acute glomerulonephritis cases.[3]

Total leucocyte count was increased in 29(14.5%) cases while impaired GTT was found in 9(4.5%) cases.

The drug sensitivity pattern showed that *staphylococcus aureus* was highly sensitive to ofloxacin 103 (96.2%) followed by erythromycin 100(93.45%) and gentamicin 76(71.02%) while *Bhaemolytic streptococcus* was also highly sensitive to ofloxacin 41(95.3%) followed by erythromycin 38(88.3%) and gentamicin 36(88.7%).

The paucity of such a study from Western Rajasthan prompted us to report our observations.

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Treatment of nodular scabies

To the Editor:

Nodular scabies (NS) presents as pruritic, persistent nodules for weeks or months even after successful treatment of scabies. Scabicidal drugs include 5-10% sulfur, 25% benzyl benzoate, 1% gamma benzene hexachloride, 25% monosulfiram, 5% permethrin, 5- 10% thiabendazole and 10% crotamiton. Other modalities for treating nodules in scabies include intralesional steroids and surgical excision.[1] Crotamiton is the only antiscabies agent having antipruritic as well as antibacterial properties.[2] Topical crotamiton (10%) alone or with hydrocortisone (0.25%) have been successfully used in treating NS.[3]

One hundred cases of NS were diagnosed clinically and confirmed histopathologically from the Department of Skin and STD, Rajindra Hospital, Patiala from Feb. 95 to Dec. 96. After treating routine lesions of scabies,