cellulitis, and maculopapular plaques or nodules. Ecthyma gangrenosum is considered by many authors as pathognomic of Pesudomonas sepsis, though occurring in only 1.3% to 6% of patients with Pseudomonas bacteremia.[1] Although usually caused by P aeruginosa, it has been described in a case of P seudomonas cepacia endocarditis.[2] Lesions can occur anywhere but are usually found in the anogenital region, buttocks, extremeties, abdomen and axillae. In non-bacteremic ecthyma gangrenosum, the lesion is actually located at the site of entry of the organism into the skin; as opposed to classic ecthyma gangrenosum where the lesions represent a blood-borne matastatic seeding.[1]

This rare case of non-bacteremic ecthyma gangrenosum is consistent with earlier reports[1] having female predominance and better prognosis as compared to patients with Pseudomonas bacteremia, though occurring at a rare site.

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SILENT RENAL CARCINOMA PRESENTING AS CUTANEOUS METASTASIS

To the Editor,

Cutaneous metastasis of renal adenocarcinoma is rare.[1] A 70-year -old woman came with history of restricted movement of left upper arm of 3 months duration. A hard mass was noticed measuring 8x8 cm in left scapular region fixed to underlying muscles. Skin over the mass was pinchable and normal. Patient was anaemic, not jaundiced and there was no generalized lymphadenopathy. There was no organomegaly. Bowels and micturition were normal. Abdomen was scaphoid, soft, and no mass was palpable. Renal angles were free. Biopsy of left scapular mass revealed clear cell type of carcinomatous cells in sheets, and glandular pattern; separated by thin fibrous septa. The nuclei were centrally placed. Ultrasound of abdomen revealed 6.4x4.1 cm size hypoechoic mass arising from the lower pole of left kidney. General condition of the patient deteriorated and she became unfit for surgery. The diagnosis of silent renal cell carcinoma of left kidney with cutaneous metastasis was made.

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PAUCITY OF IMMUNE COMPLEXES IN SKIN LESIONS OF LICHEN PLANUS

To the Editor,

This is with reference to the article entitled "Paucity of immune complexes in skin lesions of lichen planus"[1] published recently in the Journal. We wish to share our experience on direct immunofluorescence (IMF) in lichen planus(LP). As reported by the authors we have also observed colloid bodies showing IgM, IgA, IgG and C3 deposits, however, in addition to the above we have consistently observed a

ragged fibrin band deposit along the dermoepidermal junction. The consistent presence of fibrin has been reported by other authors.[2,3] In addition, the authors have correlated the presence of positive IMF staining of colloid bodies with the age of the lesion. Although we have not correlated the presence of colloid bodies with the age of the lesion, we have detected its presence in almost all cases, except in the oral mucosa. Paucity of colloids in the oral mucosa has been reported.[4] To conclude, we feel that the presence of fibrin band should be looked for in LP.

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ERYTHROMELALGIA RESPONDING TO ASPIRIN

To the Editor,

A 14-year-old dumb girl was brought for the complaints of white soddening of the skin of both hands of 2 weeks duration. History revealed that the patient had for the past 3 months constantly immersed her hands in water. On examination, patient had candidal intertrigo of the webs of the fingers with keratolysis punctata of both hands. Skin over the hands was red and warm. Peripheral pulses were normally felt. Lower extremities were normal. There were no features to suggest any collagen vascular disease or peripheral occlusive vascular disease. Investigations revealed a normal RBC, platelet and WBC counts. ESR was normal. Rheumatoid factor and ANA were negative. A diagnosis of erythromelalgia was made and the patient was put on tab aspirin 1/2 tab per day and was simultaneously treated for candidal intertrigo. Response was dramatic. Patient stopped immersing her hands in water and the warmth and redness of the hands decreased considerably.

Erythromelalgia is a condition of painful red extremities in which a sensation of burning is associated with an increased temperature in the affected limb.[1] There are 3 types of erythromelalgia.[2] Our patient with bilateral involvement is likely to belong to type 2. This type is generally confined to the lower legs and is thought to share similarities with reflex sympathetic dystrophy. It usually does not respond to aspirin and may require sympathetic blockade for relief of symptoms. Aspirin is useful in treatment of type 1 in which there may be thrombocythaemia or other defects of platelet functions. It acts presumably by preventing platelet aggregation.[3] This type is generally seen in persons past their middle age.

It may be worthwhile trying aspirin in all cases of erythromelalgia as many patients irrespective of the type get considerable relief. Regular follow up of our patient is essential as erythromelalgia may be a presenting and premonitory symptom, often by several years. of myeloproliferative disorders like polycythaemia vera and thrombocythaemia.

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