months. Nails revealed no abnormality, past history revealed that the patient was admitted in BS Medical College & Hospital, Bankura for sulphonamide-induced Stevens - Johnson syndrome (SJS). At that time patient was treated with steroids, associated IHD with CCF was also diagnosed and managed with digoxin and dytide (thiazide) drug for one week.

Routine laboratory investigations showed - Hb 4.8gm%; TLC 10,000/cumm; DLC N 45%, L 40%, E 15%; ESR - 75mm in 1st hour; platelet count 2,60,000/cumm; LE cell (-)ve; ANF (+)ve; VDRL (-)ve; Urine : epithelial Cells - a few, pus cell 3-5/HPF, RBC nil, cast nil; chest X-ray slightly enlarged cardiac shadow in transverse diameter with ventricular predominance but no lung parenchymal or hilar abnormality; ECG - IHD with left ventricular strain pattern. Skin biopsy from the representative lesion was compatible with SCLE. The patient was put on low dose prednisolone (30mg/day) and chloroquine phosphate (500mg/day). After 2 weeks of therapy she responded well.

The patients of SCLE are usually young and middle aged white women of 15 to 40 years.[3] It is very uncommon in blacks of either sex. The cutaneous lesions of SCLE are differentiated from the generalised DLE on clinical grounds alone.[1] In contrast with marked systemic illness in systemic LE, SCLE patients frequently have mild systemic illness and no serious CNS, renal or systemic vascular involvement; yet half of the patients fulfill the ARA criteria for SLE.[2] Thin, easily detachable scales, psoriasiform lesions in striking distribution pattern with positive ANF, anaemia, raised ESR, musculoskeletal complaints, fever and compatible skin biopsy report helped in the diagnosis.

However, in this case it is yet to be established whether such a short term therapy with sulfonamide or thiazide could be a precipitating factor of SCLE.

B Sengupta, JN Sarkar, P Bhattacharya, MK Barman, MK Sharma
Bankura

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CONNECTIVE TISSUE NAEVUS - NAEVUS ELASTICUS

To the Editor,

Juvenile elastoma (naevus elasticus) is a connective tissue naevus of elastin that may occur as a sporadic isoloated lesion or multiple lesions as the Buschke-Ollendorf syndrome.[1,2] We, herewith, report a case of juvenile elastoma in a 21-year-old male for its rarity and clinical interest.

A 21-year-old male noticed an asymptomatic gradually increasing swelling over the midline of back for last 5 years. There was no history of seizures. No family history of similar lesions was forthcoming. Cutaneous examination revealed a single, oval, soft to firm, 3x4 cm subcutaneous swelling with dermal infiltration at T12 level in the midline

back. Overlying skin, which had an "orange peel" appearance, was topped by 2 to 3mm sized soft papular lesions numbering five in total and a 5 mm sized hyperpigmented, raised soft nodule having furrowed skin. No ash leaf macules, adenoma sebaceum, cafe-au-lait macules or neurofibromas were seen. Rest of cutaneous and systemic examination was unremarkable. Routine laboratory examination was within normal limits. Skiagram of dorsolumbar spine did not show any abnormality. Microscopic examination of the lesions showed mild hyperkeratosis in the epidermis. The reticular dermis showed collagenisation. Verhoff-Von Gieson stain showed marked increase in the elastic fibres but there was no evidence of degeneration of elastic fibres.

The term naevus elasticus was first used by Lewandowsky[3] under the title of "Naevus Elasticus Regionis Mammariae" to describe a condition appearing in the pectoral regions and being characterised by groups of perifollicular papules which histologically showed disappearance and degeneration of the elastic fibres. Staricco and Mehregan,[2] however, later emphasized the use of the term naevus elasticus for a localised naevoid disturbance of elastic fibres, characterised by pure excess of normal appearing fibres. The use of term naevus anelasticus for Lewandowsky's naevus was justified. The naevus elasticus has been described under a variety of names such as dystrophia elastica follicularis thoracica, naevus pseudocolloid perifolliculaire, naevus conjunctivus and juvenile elastoma.[2] It is generally found in young children and is characterised by skin coloured or white-yellowish tumours varying in size from few mm to one centimeter, isolated or grouped in plaques, generally distributed on the back, the lumbar regions, the abdomen and thighs.[2] The features observed in our case were compatible with sporadic isolated form.

These connective tissue naevi are subtle at birth and may go unnoticed. They tend to persist throughout the life. Clinically, the appearance is so characterisitic that they are seldom misdiagnosed.

Devinder Mohan Thappa,
BR Garg, C Ratnakar
Pondicherry

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NAEVUS LIPOMATOIDES CUTANEOUS SUPERFICIALIS

To the Editor,

Naevus lipomatoides cutaneous superficialis (NLCS) was first described by Hoffmann and Zurhelle in 1921.[1] This is an uncommon naevus showing groups of soft populonodules of pale yellow colour. They start in the first two decades.[2] Only 8 cases of NLCS have been reported in Indian literatute[3] and around 130 cases in the world literature.[4] This condition is due to the presence of ectopic fat cells in the dermis which are derived from the perivascular mesenchymal tissue.[2]

A 35-year-old female was seen with multiple grouped asymptomatic nodules over the left hip. Lesions started at puberty and gradually increased in size. There was no family history of similar lesions. On examination there were multiple yellowish