confirmity with other published studies.[2]

The majority of our patients (23) were active workers [farmers(7), drivers (3), labourers (5) and semiskilled workers (8)] doing strenuous physical work leading to profuse sweating. Most of our patients were wearing tight and synthetic clothes which caused more warmth and moisture of the body. These factors made the body surface suitable for the growth of dermatophytes and led to the high incidence of tinea cruris and tinea corporis cases. The high incidence of tinea unguium in our study might be due to the trauma inflicted to the nails as a result of hard physical work and habit of walking and working barefooted.

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CUTANEOUS DRUG REACTIONS

To the Editor,

A clinical study of cutaneous reaction was carried out at B J Medical College and Civil Hospital, Ahmedabad, for 1 year duration. Out of total 12,500 patients, cutaneous drug reaction was present in 200 cases (1.6%). Out of 200 cases 106 were male and 94 were female. Age was ranging from 1 year to 85 years. Mean age was 40.7 years. With the help of clinical history, physical examination and laboratory investigations to rule out any systemic disease an attempt was made to establish offending drug in each case, in few cases of fixed drug eruption therapeutic chellange test was carried out for confirmation of diagnosis.

In present study, highest incidence noted was of fixed drug reaction in 54 (27%) patients. In males lesions were found of glans penis, extremities and lips, while in females they were more detected on lips, thigh and on face. Common offenders were sulpha group, analgesics and paracetamol.[1] Urticaria was present in 48 (24.0%) cases, erythema multiforme in 27 (13.5%), monomorphic acne in 15 (7.5%), lichenoid rash, erythema multiforme rash in 8(4.0%), S J syndrome in 8 (4.0%), angio-oedema in 9 (4.5%), purpura in 4 (2.0%) patients, pigmentation and maculopapular rash in 3 patients each. Pityriaris rosea like rash, striae atrophicans and exfoliative dermatitis in 2 patients each, while anaphylactic shock and gingival hyperplasia and toxic epidermal necrolysis in one patient each, were present. Main offending drugs were analgesics and antipyretic (94 patients), antibiotics (51 patients), antituberculous (11 patients), steroids (8 patients), anti-convulsants (6 patients), anti-malarials (6 patients), anthelminthic (4 patients), anti-leprosy (3 patients), hormones (2 patients) and others 15 patients. In the present study, maculopapular rash was found following ciprofloxacin and cephalexin in one patient each.

In the present study, analgesics, anti-inflammatory, antipyratics and antibiotics remain the main culprit and clinical pattern was comparable to the previous study by Hanumanthappa.[2] Unfortunately these drugs are available widely without physician's advice and are cheaper and have proved hazardous to the patients. 27.5% of cases were presented due to self-medication. Hence patients should be advised regarding hazards of

self-medication and given drug card for various drugs causing reaction and to whom he is susceptible more.

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RECALCITRANT PSORIASIS TREATED WITH TRETINOIN 0.05% CREAM

To the Editor,

Psoriasis is a common dermatological disorder affecting 1-2% of Indian population. Treatment of psoriasis is frustrating despite various modalities available. A case of recalcitrant psoriasis treated with tretinoin 0.05% cream is described.

A patient with psoriasis of over 25 years duration reported to us in November 1990, and is under our treatment since then. There was an associated history of arthralgia for 1 year with coronary artery disease and hypertension for past 3 years. At the time of initial examination, patient had extensive plaque type of psoriasis, for which he was put on conventional coal tar therapy for an appropriate period. His response was partial. Subsequent treatment comprising PUVAsol, corticosteroids and methotrexate also failed to give satisfactory response.

In May 1995, the patient reported with severe plaque psoriasis on both legs and mild-moderate plaque psoriasis on scalp and abdomen. At this time, we advised him to apply topical tretinoin 0.05% cream twice daily, only on leg lesions. Clinically evident improvement was noticed in about a week, which progressed remarkably in 4 weeks time. Subsequently, patient applied tretinoin on his own to other areas as well. After 6 weeks the patient showed complete clearing of all lesions, which had never been observed during any of the above therapeutic modalities. At 6 weeks the patient was advised to stop applying tretinoin. Patient followed till 3 months showed no relapse.

Several past studies have drawn attention to the benefit of topical retinoids in chronic skin conditions, as compared to placebos.[1-4] In psoriasis, the therapeutic value of retinoic acid seems to be uncertain. In a study by Gunther,[1] done on various forms of psoriasis, there was an improvement in 16.7% of cases of chronic psoriasis, treated exclusively by topical retinoid in the strength of 0.1%. Observed side effects in his patients were folliculitis and irritant reactions. We suggest a revival of interest in the above drug for psoriasis and a larger study for further evaluation.

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