

systemic corticosteroid therapy in cases of alopecia areata.² Pigmentary changes in nails were reported after antimalarials.³ Results of observation of nail changes induced by drugs in our study are given in table.

Sr. No.	Age and Sex	Name of drug	Dose and duration	Type of nail changes	Recovery Period
1	20 M	Ketoconazole	200mg BDx7days	Blue lunulae of thumb nails	2 months
2	35 F	Ciprofloxacin	500mg BDx7days	Blue lunulae of thumb nails	3 months
3	19F	Cefadroxyl	500mg BDx7 days	Blue lunulae of finger nails	2 months
4	46F	Cyclophosphamide and Dexamethasone	500mg IV-1st day and 50mg OD 1000mgx3 days Pulse therapy IV in 5% Dextrose		
5	50M	Carbamazepine Phenytoin Lonazepam	200mg BD-5 Yrs 200mg-BD 4 Yr. 0.5mg BD 4 Yr.	Lunula dystrophy, Pain	Persisting
6	21M	Phenytoin	200mg BD-15 day	Blue discolouration of all finger and toenails	Persisting
7	35M	Chloroquin	200mg BD	Black pigmented bands on finger nails	6 months
8	36M	Mefloquin	250 mg BDx3 days	Photoonycholysis	Lost to follow up

Age range was 19 to 50 years. There were 5 males and 3 females. Bluish discolouration¹ of lunulae² was the commonest change seen in 4/8 cases after ketoconazole, ciprofloxacin, cefadroxyl, and cyclophosphamide plus corticosteroid combination. Painful dystrophy of lunulae

was observed after combination of carbamazepine, phenytoin and lonazepam. Prominent and persistent bluish grey discolouration of all twenty nails was observed after phenytoin. Black longitudinal bands were observed in a case of DLE after chloroquin intake. Mefloquin resulted in phototoxic drug eruptions, was withdrawn, and even after 2 weeks of withdrawal resulted in photoonycholysis. Discolouration disappeared in 4 after 2 to 6 months of discontinuation of the offending drugs and persisted in 3 who were unable to stop the drugs and one patient was lost to follow up.

Nail changes, secondary to systemic drugs are rare as only 8 cases were collected during 2 1/2 yrs.

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FOOT WEAR DERMATITIS

To the Editor

Footwear dermatitis is a common disorder with an overall prevalence of 3 to 11%.¹⁻⁴ The common sensitizers are potassium dichromate, colophony and rubber accelerators.⁴ Many patients with sensitivity to potassium dichromate still prefer leather shoes. Rubber glues are used in the manufacture of leather footwear thus

making leather footwear unsafe for patients with sensitivity to rubber.

We recently had a patient who had sensitivity to potassium dichromate and rubber accelerators. As finding a suitable footwear posed a challenge we wrote to central leather research institute. The institute (Shoe design and

development center, central leather research institute, Adyar, Chennai - 600 020, India, clrid@vsnl.com) will provide footwear tanned with vegetable tannis and manufactured without rubber (if patient is sensitive to rubber) if the following information is provided.

1. Patients sensitivity profile detected by patch testing.
 2. Footprint of the patient.
 3. Volume measurement (in mm) of both legs at metatarsal.
- We submit this article to enable other dermatologists to avail this alteration.

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ICHTHYOSIS VULGARIS INVOLVING THE SCALP AREA AFFECTED BY ANDROGENETIC ALOPECIA

To the editor

Ichthyosis vulgaris is a fairly common condition and on several occasions is an incidental finding in patients presenting with other more pressing dermatoses. We recently observed the presence of ichthyosis vulgaris in a patient, with a very striking localization to the area of the scalp affected by androgenetic alopecia.

A 44-year-old patient presented to us with an itchy lichenified plaque on the left leg of 5 years duration. Examination of the patient also revealed light brown polygonal scales on the extensor surfaces of the forearms and on the scalp strictly in areas affected by androgenetic alopecia. He also had keratosis pilaris over the upper arms and hyperlinear palms. History revealed that he had started developing androgenetic alopecia 10 years ago and since then had noticed light brown scales over the bald area, which increased in winters. He took no treatment for it except local mustard oil application. There was no history suggestive of ichthyosis in his family. Biopsy of the affected area of the scalp showed compact hyperkeratosis

and follicular plugging with a markedly attenuated granular layer suggestive of ichthyosis vulgaris.

Although described,¹ we do not recall having seen such a scalp involvement in the several patients of ichthyosis vulgaris that we have come across so far. The attenuation of sebaceous glands in areas of androgenetic alopecia along with the exposure of the underlying scalp skin to the environment in the absence of terminal hair in the area could have led to the clinical manifestation of ichthyosis vulgaris at the site following the onset of androgenetic alopecia.

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