event.[3]

Lower eyelid are affected only in severe cases, and unilateral disease is uncommon.[3] This rare case of blepharochalasis was unique in that the lower eyelids were involved predominantly with lesser involvement of the upper eyelids, and there was no associated pigmentation or telangiectasia.

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VOGT-KOYANAGI-HARADA SYNDROME

To the Editor,

Vogt-Koyanagi syndrome presents as acute anterior uveitis, alopecia, vitiligo, poliosis and dysacousis.[1] Harada's disease presents as posterior uveiltis, meningeal irritation and an increase in concentration of protein and white blood cells in the CSF. The two disorders are found together, hence the term Vogt-Koyanagi-Harada (VKH) syndrome.[2] Meningeal or ocular symptoms usually appear first but in some patients vitilligo may appear before uveitis.[2] It is a rare disease and early diagnosis is important because ocular morbidity can be reduced significantly in some patients with early treatment.[3]

One 35-year-old woman presented with bilateral symmetrical periorbital vitiligo for 6 months and right facial palsy, deafness of right ear, diminished hearing (left ear) and bilateral loss of vision for 2 years and 9 months. Fundus revealed clear media and retina showed resolved oedema with pigment dispersion and few spots of healed juxta-papillary choroiditis.

In February 1992, she was admitted with sudden onset of severe headache, vomiting, moderate grade fever, generalised seizures, loss of memory, speech disturbences, attacks of loss of consciousness with incontinence of urine and stools. At that time CSF had proteins 30mg% suger 73 mg%, chlorides 132 meq/l, 5 WBCs/HPF and no AFB, Gram negative diplococci or cryptococi etc. ELISA for tuberculosis was negative. After 1 month of admission she developed blurring of vision and diplopia which progressed in a month to total loss of vision, first in left eye and then in right. She also had alopecia totalis and hair regrew after 6 months. In April 1992, she had anosmia, loss of taste sensation in anterior 1/2 tongue, nasal regurgitation, complete deafness of right ear, sensorineural deafness of left ear, right 5th, 7th, 8th, 9th, 10th and left 6th cranial nerves palsies with loss of lacrimation. She had dilated 3 mm pupils, diminished light reflexes, Marcus Gunn pupil, bilateral papilloedena, macular oedema, engorged dilated vessels and bilateral upgaze palsy. NMR revealed Arnold Chiari malformations type - I. CT scan was normal. Initially she was treated with 45 mg prednisolone and 300 mg of dilantin daily. Seizures continued and now her seizures are controlled with 300 mg of carbamazepine daily for 1 year. Slight improvement in vision has occurred during the last months. Multiple cranial nerves plasies observed in this patient were unusual. Meningeal disease was severe in our patient.

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HAEMORRHAGIC CHICKEN POX WITH PNEUMONITIS

To the Editor,

A 50-year-old man reported with complaints of fever of one week and skin and mucous membrane lesions of about 4 days duration. The individual had consulted a private practitioner prior to hospital referral and was treated with antibiotic and systemic steroids. There was no history of diabetes or any other systemic illness. He did not give any history of atopy or skin illness in self, family or immediate contact. The lesions appeared first on the trunk and then gradually extended over the peripheral parts. He had developed mucous ulcerations of the eyes, mouth and nasal cavities. This was accompanied by swelling and inability to open both eyes. The lesions tended to appear in crops and each crop was accompanied by fever of moderate grade.

Examination showed an averagely built, middle aged male individual. His temperature was 102°F and blood pressure was130/20 mm Hg. Bilateral oedema of both legs was present. Systemic examination showed diffuse coarse crepts over both lungs. Dermatological examination showed involvement of face, trunk and extremities showing multiple bilaterally symmetrical vesicular lesions, some discrete, while others showing confluence with clear to turbid fluid. Some lesions showed crusting, while others blood stained fluid with haemorrhagic borders. A few ecchymotic areas could be seen over the trunk. The mucous membrane of the eyes showed congestion with periorbital oedema. Superficial ulcers with petechial haemorrhages could be seen over the soft palate, pharyngeal walls and vestibule of mouth. Bilateral pitting oedema was present over both feet. Hair, lymph nodes and nails were normal.

A clinical diagnosis of varicella was made. Haematological and biochemical parameters were within normal limits. HIV test was negative. Tzanck smear from one of the blisters showed presence of balloon cells.

He was treated with I V ampicillin, gentamycin, Inj. cephalexin & I V acyclovir along with other supportive measures. After 2 days of hospital admission he developed delirium and started showing abnormal behaviour. A CSF Examination done at this stage was normal. On 4th day he had a massive bout of haematemesis, developed coma and expired. X-ray chest showed widespread 10 mm diameter nodules, some discrete and others confluent bilaterally. No hilar opactities or lymph node enlargement was seen. Nodules had ill defined margins. No cavitation was seen within any nodule.

Chicken pox though fairly common in children, occurs occassionally in adults and is known to be more severe in adulthood. Our patient had severe involvement of skin and mucous membranes along with pneumonitis and possible meningeal involvement. Pneumonitis, though unusual, occurs and is characterised pathologically by interstitial scattered lesions with nodular haemorrhagic areas. Microscopy shows characteristic findings of focal peribronchial necrosis, intracellular inclusions and bibrinoleukocytic exudates.[1]

Haemorrhagic varicella is rare. This disease is accompanied by high fever and a