At this juncture he consulted our clinic. Patient was prescribed local steroid (Elocon; mometasone furoate 0.1%) once a day for 3 weeks.

Provocation test done later, using 125 mg oral ciprofloxacin, produced erythematous hallow around the previous pigmented patches. Patch test with ciprofloxacin was not performed.

Ciprofloxacin is a well tolerated drug. Side effects reported are nausea, abdominal discomfort, headache and dizziness.[2] Cutaneous rashes such as photosensitivity has been reported.[3]

Antibiotics, sulfonamides and their derivatives and antiinfective agents causing FDE are common.[1,4] Nonetheless, the newer quinolones producing FDE have not yet been reported except very few cases with ofloxacin[5] and a single case with ciprofloxacin only from Japan.[1] This case indicates that due to extensive use of ciprofloxacin in more than 56 countries other similar cases may come to light in future.

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KYRLE'S DISEASE

To the Editor,

Kyrle's disease is a rare disorder of keratinization. It usually presents as multiple hyperkeratotic follicular and parafollicular papules with a central keratotic plug. The cause of disease is not known but it may be associated with diabetes, chronic renal failure and hepatic dysfunction.[1,2]

A 23-year-old man presented with slowly progressive mildly pruritic, painless, discrete polygonal, symmetrical, hyperkeratotic papules of 0.5 cm to 1.0 cm size, on the extensors of upper limbs, lower limbs and on buttocks. In the centre of papules a cone shaped keratotic plug was present which was readily removed with the help of curette. Routine examinations of blood, urine and stool were within normal limits. Patient was not having diabetes mellitus, renal failure or hepatic dysfunction. The clinical diagnosis of Kyrle's disease was made which was subsequently confirmed by the histopathological examination by presence of hyperkeratosis and parakeratosis of epidermis and a keratinous mass seen penetrating the follicular wall at places with dermal infiltrate predominantly of lymphocytes.

It is thought that metabolic disorders associated with Kyrle's disease are somehow responsible for development of abnormal keratinization and connective tissue changes,[3] but the actual mechanism may be different as in our case the Kyrle's disease was seen in otherwise healthy adult male.

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HIV SEROPOSITIVITY IN TRUCK-DRIVERS

To the Editor,

Truck drivers are one category of high risk group for getting HIV infection due to their occupational travel. So an attempt was made to study the extent of problem of seropositivity in this high risk group.

Three hundred and three truck drivers passing from Pune-Ahmednagar, Maharashtra State highway were contacted in December 93, were interrogated, clinically examined and also their blood samples were taken for examination to know the HIV status among this high risk group. 282 sera could be tested for ELISA. Those positive for ELISA were also tested for western blot test. Sixteen were positive for ELISA as well as western blot test. While remaining 250 sera were negative for both the tests. HIV positivity rate was 5.67%.

Among the 16 with both tests positive, 8 were unmarried and gave history of visiting prostitutes and not using condom. The age group was from 20 to 34 years. Mahajan et al[1] have studied truck drivers of Gurudaspur district of Punjab and the prevalence of HIV positivity among them was 7.27/1000. In the present study it is seven times more. Studies in Manipur have shown a high prevalence of STD and HIV in places where trucks traditionally halt.[2] ICMR has reported very high seropositivity rate of about 30% in commercial sex workers.[3]

Such a high risk group is needed to be given health education regarding AIDS and other sexually transmitted diseases with special reference to the role of condom in protecting both the partners.

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SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS

To the Editor,

A 35-year-old woman presented with itchy, slowly progressive, erythematous discoid plaques ranging from 1 cm to 4 cm in diameter present over left pinna, tip of nose and alae nasi, left cheek, upper chest, upper back and left forearm for the past 6 months.

Most of the lesions showed atrophic surface with depigmentation, coarse adherant scales and plugged follicular orifices, while the lesions on the upper back were annular with mild pigmentary changes and fine scaling. Scalp showed a non-scarring skin-coloured plaque, about 1cm x 4cm in size, with uneven surface and prominent follicular orifices. Tin-tack sign was positive.

Associated complaints were increased itching and redness over plaques on sun exposure, anorexia, on and off vertigo, persistent joint pain in elbows, wrists, knees and ankles, and cyanosis of fingers with swelling and pain on dipping in cool water, which got relieved on warming.

The following investigations revealed significant results: ESR 58 mm in 1st hour, 24 hour urinary protein 300 mg, RA factor