LETTERS TO THE EDITOR

UNILATERAL MELASMA

To the Editor,

Melasma is a common acquired pigmentary disorder, usually seen in women of child bearing age.[1] Its association with pregnancy and oral contraceptives is well known.[2] Endocrine abnormalities and nutritional deficiencies have also been incriminated in its aetiopathogenesis.[3] The lesions are predominantly distributed over photoexposed areas and are usually bilateral and symmetrical.

We recently saw a middle aged housewife with asymptomatic blotchy dark brown hyperpigmentation on right side of face of 6 years duration. She developed this pigmentation during her second pregnancy and gradually the lesions increased in size and darkened in colour. Following the delivery there was mild fading of colour for initial few months but with usage of oral contraceptives the lesions started darkening again. There was no seasonal variation; however, she noticed prominance of lesions on exposure to sun. Her menstrual periods were normal and there was no family history of similar disorders. She denied use of any cosmetics or any other drugs apart from oral contraceptives. Examination revealed macular dark brown pigmentation with irregular borders over right malar region. There was no erythema, telangiectasia or atrophy. Periorbital area, oral mucosae, conjuntivae and sclerae where devoid of any such discolouration. Other parts of the body did not reveal any pigmentation. A diagnosis of melasma limited to one side of face only was made. She was prescribed lactocalamine locally during the day and potent topical corticosteroids (clobetasol propionate 0.5%) at night. Within 8 weeks there was significant cosmetic improvement.

Other possibilities which were considered and subsequently excluded in this patients on the basis of history and examination were melanocytic naevus, naevus of Ota, pigmented cosmetic dermatitis (Riehl's melanosis), poikiloderma of civatte, occupational melanosis, lichen planus pigmentosus, lichen planus actinicus, fixed drug eruption, macular amyloidosis and urticaria pigmentosa. In our opinion a duration of 6 years is sufficient for lesions of melasma to appear on other side of face to maintain its bilateral uniquity. The unilateral nature of this common disorder is striking.

Goutam Dawn, Sandipan Dhar,
Amrinder J Kanwar
Department of Dermatolgy, Venereology & Leprology, Postgraduate Institute of Medical Education & Research
Chandigarh - 160 012, India

References

1. Newcomer VD, Lindberg MC, Sternberg TH. A melanosis of face (chloasma). Arch Dermatol 1961; 83 : 224-99.
2. Bleehen SS, Ebling FJG, Champion RH. Disoders of skin colour. In : Text Book of Dermatolgy (Champion RH, Burtion JL, Ebling FJG) 5th edn. Oxford : Blackwell Scientific Publications, 1992; 1596-7.
3. Kanwar AJ, Kaur S. Treatment of melasma. Drugs Bulletin (PGIMER) 1989; XII (1) : 16-28.

TWENTY-NAIL DYSTROPHY

To the Editor,

A 20-year-male, dental student, presented with asymptomatic disfigurement of all 20 nails since age of 8 years. Onset was over the thumb and great toe nails, with

gradual involvement of all the remaining nails within a period of one year. Nails were opalescent and dull with loss of nail lustre. They were thin and fragile, and had closely-set longitudinal striations.

The second case was a 28-year-female farmer who presented with thickened, brown and irregular nails of 22 years duration. Onset was simultaneous over all finger and toe nails. There was loss of nail lustre, longitudinal striations and onycholysis.

Similar nail chages in family members; or any evidence of lichen planus, psoriasis or alopecia areata was not found in both of the above patients. Nail clipping for KOH preparation and culture was consistently negative.

Hazelrigg et al, in 1977, proposed the term "twenty-nail dystrophy" for onychodystrophy of all 20 nails without antecedent disease. Its causes include lichen planus, alopecia areata, psoriasis, other inflammatory dermatoses or it may be idiopathic.[1] Other rarer causes are ichthyosis vulgaris, selective IgA deficiency, familial severe cases and ectodermal dysplasias.[2]

Twenty-nail dystrophy is an idiopathic nail dystrophy which begins insidiously and asymptomatically in early childhood (18 months to 12 years).[3] Onset may occur simultaneously in all the nails or in individual nails gradually over many months.[4] It is self limited and resolves slowly with age.[3]

Both of my cases of idiopathic tewenty-nail dystrophy had onset in childhood, consistent with earlier findings.[3] However, there was no evidence of resolution of nail chages in either patients.

K Krishna
Department of Skin and VD, Rural Medical College, Pravara Medical Trust, Loni-413736, India

References

1. Horn RT Jr, Odom RM. Twenty-nail dystrophy of alopecia areata. Arch Dermatol 1980; 116 : 573-4.
2. Baran R, Dawber RPR. The nail in childhood and old age. In : Diseases of the nails and their management (Baran R, Dawber RPR, eds). Oxford : Blackwell Scientific Publications, 1984 : 105-20.
3. Hazelrigg DE, Duncan WD, Jarratt M. Twenty-nail dystrophy of Childhood. Arch Dermatol. 1977; 113 : 73-5.
4. Silverman RA. Paediatric disease. In : Nails : Therapy, Diagnosis, Surgery (Scher RK, Daniel CR, eds). Philadelphia : WB Saunders, 1990; 82-105.

FAMILIAL INCIDENCE OF SCHAMBERG'S DISEASE

To the Editor,

I wish to report a case of familial incidence of Schamberg's disease. An adolescent girl aged about 14 years came with pigmented purpuric lesions confined to the lower limb below the knees of 6 months duration. Lesions are macules of varying sizes. An interesting finding in this case is her brother was also suffering from similar disease of 3 years duration. They were slowly disappearing on their own. By examining her brother it is confirmed clinically that it is also Schamberg's disease. Familial cases of Schamberg's disease are rarely reported.

N Lakshmi Kumari
Hyderabad - 500 042.