Hakim 2 ½ months back for hemiparesis, then d-penicillamine in dosage of 250 mg Q I D given for 10 days. Then patient had complete relief and systemic steriods are maintained for 1 month in tapering dose. Exfoliative dermatitis due to heavy metals is rare.

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SQUAMOUS CELL CARCINOMA FROM LIMBUS OF EYE IN XERODERMA PIGMENTOSUM

To the Editor,

Ocular neoplasms arising from the eye, excluding those of eyelids constitutes 11% Xeroderma pigmentosum (XP) patients.[1] They are most frequently arising from the limbus and are predominently sqamous cell carcinomas (SCC). Recently there was a case report of malignant melanoma of skin and SCC of the eye arising from limbus in an adult XP patient.[2]

A 6-year-oid male, youngest child of a consanguineous parents had multiple freckles and hypopigmented atrophic macules on sun exposed parts of the body since 4 years of age. He had photophobia, blepharospasm and increased lacrimation. Developmental mile stones were normal and no neurological manifestations were noticed.

Both the sisters of the patient developed XP, while his only brother was healthy.

Patient developed a small nodular growth 1 month back, situated at 5 O'clock position at the limbus of left eye. During 1 month, it attained the size of 1.5cm X 1cm grayish brown raised growth encroached upon cornea completely and growth was protruding out about 0.5cm. Child had pain, irritation and could not close the eye. There were no metastases.

Routine investigations were normal including LFT. X-ray chest found normal, skin biopsy confirmed the diagnosis of XP. Enucleation of eyeball was inevitable. Histopathology of the growth revealed as well differentiated SCC.

Neoplasm of the eye in XP confined almost exclusively to the conjuctiva, cornea and eyelids, those portions of the eye exposed to ultraviolet radiation. These tissue sheild the iris, lens and retina from ultraviolet radiation.

Unique review of 830 published cases of XP in a span of 108 years by Kraemer et al[1] revealed that neoplasms occured most frequently at the limbus followed by the cornea and conjuctiva. The most frequent histologic type reported was SCC.

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ATOPIC DERMATITIS OF SCALP

To the Editor,

Though diffuse scaling of the scalp in children and adults with atopic dermatitis (AD) is a result of subacute dermatitis due to Pityrosporum ovale :[1] frank eczema over scalp as a manifestation of AD is certainly very rare. Eczema restricted to scalp alone has so far not

been mentioned in standard texts on atopic dermatitis.[2]

We recently observed a patient with chronic eczematous lesions over scalp in whom diagnosis of atopic dermatitis of scalp was made.

A 9-year-old boy presented with moderately pruritic oozy lesions restricted to scalp of 3 years' duration. There was history of remissions and relapses during the course of the disease. No personal or family history of atopy was available. Examination revealed eczematous lesions restricted to scalp. Retroauricular and nasolabial folds were spared. The child in addition had Dennie-Morgan infraorbital folds, peri orbital darkening, pityriasis alba, xerosis and keratosis pilaris.

A provisional diagnosis of AD of scalp was made. Other possibilities considered were infectious eczematoid dermatitis (IED) and seborrhoeic dermatitis. A chronic course of the disease with frequent relapses and remissions and lack of an infective focus as primary lesion substantially ruled out the possibility of IED. Seborrhoeic dermatitis was excluded as it probably does not occur at this age; sparing of other seborrhoeic areas of the body and absence of greasy scales.

Though to diagnose atopic dermatitis, constellation of 3 basic and 3 minor criteria have to be there, it is not always so. The above patient did not had 3 basic features but still a diagnosis of AD was made. In such a situation, minor criteria come to rescue. The patient fulfilled 5 minor criteria.

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COMPARATIVE STUDY OF VARIOUS DRUG REGIMENS IN VITILIGO

To the Editor,

We read with great interest the article Patel et al.[1] The authors have compare efficacies of 4 different regimens in th treatment of vitiligo. All these 4 regimens ha injection of placental extract and topic 0.25% fluocinolone acetonide in common. T these, oral levamisole was added in regime III, PUVA-SOL and oral betamethasone regimen IV. The authors have also claime that though the result in regimen I was n that encouraging; in regimen II and IV we found to be very good and the results ha been compared with that of Pasricha et al.[2]

Pasricha et al[2] evaluated 5 differe regimens for the treatment of vitiligo follows : regimen I consisted to on levamisole, regimen II levamisole with 0.1 topical fluocinolone acetonicle, regimen III o betamethasone added to regimen II, regime IV oral betamethasone with PUVA-SOL a regimen V betamethasone minipulse (5 m twice a week) with oral cyclophosphamide. S the regimens used were quite different th those of Patel et al and none of the contained placental extract injection. W