LETTERS TO THE EDITOR

POST KALA AZAR DERMAL LEISHMANIASIS

To the Editor

The article *Post-kala-azar Dermal Leishmaniasis by Padhiar* et al. in the latest issue of the Ind J Dermatol Venereol Leprol 1998; 64:243-244, highlights the fact that uncommon dermatosis prevalent in a particular area can be seen elsewhere due to migration of people to earn their livelihood. What rather confuses the reader short of distorting the facts are certain unusual observations that are conveniently left unexplained.

1. The opening word in the introductory part starts with "Post-kala azar dermal leishmaniasis....." and what follows does not make sense at all. However sense would be restored if the word is read as "kala-azar" instead of "Post-kala-azar dermal leishmaniasis".

2. The most typical presentation of post-kala-azar dermal leishmaniasis (PKDL) pertains to the face which is nearly always involved. No mention has been made of this unusual feature.

3. Peripheral smear (which one would understand as a peripheral blood smear) has been reported to be positive for Leishmania donovan (LD) bodies, the diagnostic feature of PKDL. This is very surprising for there is not a single report to my knowledge in the literature which mentions this observation. More surprising is it for the reader to learn that repeated slit-skin smears were done for AFB, but not once for L.D. body!

4. The combination of splenomegaly, lymphadenopathy, atypical clinical features and presence of L.D. bodies in the peripheral smear would make the diagnosis of PKDL a remote possibility.

5. Rifampicin and ketoconazole were given as treatment. This is again a deviation from the standard procedure which recommends sodium antimony gluconate injections since these drugs have been found to be ineffective in PKDL. The authors have not at all explained the rationale nor has the follow up of the patient been mentioned (since it has to be assumed by the reader that this combination was effective in this report).

These lapses cannot simply be ignored without proper explanation. Further the authors have not resorted to the large number of good clinical descriptions of this interesting dematosis in the Indian literature. The discussion is again a carry over of the major lapses in the report. Without even mentioning the presence of LD bodies in the histopathologic description the authors seem to have confirmed PKDL when writing the discussion! It would be informative to know the authors view on the points raised above.

Dr. V Ramesh
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NAIL CHANGES SECONDARY TO SYSTEMIC DRUGS

To the Editor

Systemic drugs can affect nails and nail changes range from pain, colour change, shedding or loss of the nail plate. Nail changes after drugs can be due to toxicity to the matrix, nail bed or hyponychium and to the periungual structures.[1] Red lunulae were described after