irradiation etc. So herpes zoster should be considered a potentially infectious or contagious disease.

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MALIGNANT ACANTHOSIS NIGRICANS

To the Editor,

Acanthosis nigricans (AN) which is associated with malignancy usually occurs after 35 years of age, is quite extensive with involvement of mucous membranes, palms and soles and has accompanying pruritus. Most commonly associated malignancies are adenocarcinomas of gastrointestinal tract.

A 38-year-old female had generalised pruritic hyperpigmentation and brown velvety, verrucous lesions in flexors for past 4 years. Her oral and genital mucous membranes were velvety and hypertrophic, palm and soles were thickened and pigmented and dorsa of the hands showed fine papular lesions. For the last 3 years she had developed off and on pain in epigastrium with loss of weight and appetite and generalised weakness. For past 8 months, she had also developed two linear rows of hyperpigmented lesions with warty surface besides the verrucous lesions of AN. She was admitted to hospital and during the stay she developed migratory pain and swellings in the right arm and above the left eyebrow. This was diagnosed as migratory thrombophlebitis. Routine investigations, skiagrams of chest and pituitary fossa, barium series and USG of both upper and lower abdomen were normal. Histologically lesions from cubital fossa were acanthosis nigricans and those on breast were seborrhoeic keratosis. USG was repeated during subsequent visit to hospital two months later and it showed a mass 2"x1" involving the body of pancreas.

Acanthosis nigricans and suddenly erupting seborrhoeic keratosis are known markers of internal malignancy and association between the two is known. The presence of both in our patient suggested the presence of some internal malignancy which came out to be carcinoma of the body of pancreas.

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BENIGN MUCOUS MEMBRANE PEMPHIGOID SIMULATING GENITOULCERATIVE DISEASE

To the Editor,

A 45-year-old male patient had recurrent vesiculobullous lesions on the prepuce, coronal sulcus and glans penis for 5 years. There was burning micturition, moderate itching and pain. There was no history of extramarital sexual contact or any constitutional symptoms. Multiple ulcers, tender 3 mm to 3 cm in size, variable in shape with well-defined non-indurated margins and red granulation tissue were seen on the glans penis, shaft of penis and undersurface of prepuce. In addition a few small, 4 mm to 1 cm tense bullae containing clear fluid were also seen. Mucosa around the ulcers and bullae was whitish, wrinkled and firm. Regional lymph nodes were not enlarged. Histopathologically moderate acanthosis, small splits in basement membrane zone and one big bullae extending to full epidermis were seen. Dermal fibrosis,

mononuclear infiltrate, dilated dermal vessels with thickened walls and perivascular mononuclear infiltrate were observed. Lesions partially responded to 20 mg prednisolone OD for 2 months and later 10 mg OD for 4 months. Then he developed new bullae. Steroids were discontinued and final diagnosis of benign mucous membrane pemphigoid (BMMP) was established after excluding various genitoulcerative diseases. Circumcision had no benefit. Excellent response to dapsone 150 mg daily was observed as lesions healed completely in 42 days. Patient is now free of disease with dapsone 150 mg daily for 7½ months.

BMMP localized only to genitals is rare. We are reporting this rare case as it can mimic genitoulcerative disease and its differentiation from them is essential. Dapsone as observed by others,[1] has given excellent results in the present case.

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SEBORRHOEIC KERATOSIS OF THE EXTERNAL GENITALIA

To the Editor,

Seborrhoeic keratosis is a common, benign condition of the skin. It does not usually appear before middle age.[1] Upper trunk and the face are the sites classically involved.[2] but lesions are also frequently seen on the extremities.[3] We report a case of seborrhoeic keratosis with lesions restricted to the skin on and around the genitalia.

A 32-year-old male patient noticed asymptomatic pigmented papular lesions on the dorsal aspect of the shaft of the penis 2 years back. Since then he developed similar new lesions on the scrotum and suprapubic area. There was no history of similar lesions elsewhere on the body. The patient was married and had two children. There was no family history of similar disease. He had no symptoms indicative of any systemic disease.

General physical and systemic examination revealed no abnormality. Cutaneous examination revealed multiple discrete, light brown flat papular lesions of 3 to 6 mm size on the dorsum of the shaft of the penis, scrotum and suprapubic area. All lesions had soft velvety surface and "stuck on" appearance. The perianal area, buttocks and rest of the body surface were free. The genital and oral mucosae were normal. Histopathological examination revealed marked acanthosis. No vacuolated cells were seen. Dermis was unremarkable.

Even though seborrhoeic keratosis can occur on any body site,[2] our patient seems to have an interesting presentation. Strict confinement of these lesions to skin on and around the genitalia and sparing of classical sites is unusual. Also the lesions presented at a relatively younger age. To the best of our information, seborrhoeic keratosis is not reported exclusively on and around the genitalia. Moreover, seborrhoeic keratosis in this location resembles verruca plana[4] more closely than at any other site and a high index of suspicion is essential for correct diagnosis.

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