produced blood streaked sputum. Since 15 days, he was having difficulty in getting up form sitting position because of pain and weakness in thigh muscles. On examination there was mild pallor and a temperature of 100^0 F. There was generalised thickening of skin and diffuse alopecia. He had tenderness in both knee joints and restriction of movements (especially extension) of left knee joint because of gross thickening of skin on medial side of thigh from groin right upto the knee joint. The underlying muscles were swollen and extremely tender. Per abdominal examination showed hepatosplenomegaly. Other examination of musculoskeletal system showed a generalised decrease in muscle power but mainly the proxymal muscles were involved. Investigations showed Hb 9.5 gm%, normal total and differential counts, urine (routine and microscopic) was normal. Liver function tests and renal function tests were normal. ECG and X-ray chest were normal. Fundus examination was normal. Ultrasonography of abdomen revealed hepatosplenomegaly. Sputum for AFB was negative. Skin biopsy showed features of scleroderma, muscle biopsy revealed features of chronic myositis.

So this patient was having features of both scleroderma and polymyositis. The joint pains, pulmonary symptoms and diffuse thickening of skin and nonscarring alopecia were features of scleroderma in this patient, while the muscle weakness which was present in the proximal muscles was the feature of polymyositis. Thus our patient was a case of overlap syndrome which is a mixed connective tissue disorder characterised by a combination of features of multiple collagen vascular diseases.

K C Khare, Sanjay Khare, G Mathew
Indore

MYCOLOGICAL ASPECTS OF DERMATOMYCOSIS

To the Editor,

Please refer to Letter to the Editor entitled "Mycological aspects of dermatomycosis in Yavatmal (Maharashtra)" by KV Ingole et al. We want to share our observations in a similar study done in our institution during the period January, 1995 to December, 1995.

From 298 clinically diagnosed cases of tinea infections, skin scrapings/nail clippings/ hair specimens were examined for the presence of fungal elements by direct microscopic examination in 10% KOH solution. 195 cases (65.43%) were KOH positive and they were further subjected to culture study on Sabouraud's dextrose agar media. 140 cases (71.80%) showed culture growths of pathogenic dermatophytes.

The commonest dermatophyte isolated was Trichophyton rubrum (88 isolates, 62.86%) followed by Trichophyton mentagrophytes (50 isolates, 35.71%), Trichophyton tonsurans (1 isolate, 0.7%) and Epidermophyton floccosum (1 isolate, 0.7%).

Trichophyton rubrum was found to be the main aetiological dermatophyte species responsible for dermatophytoses in our region (62.86%), followed by Trichopyton mentagrophytes (35.71%). This is in confirmity with other published reports.[1]

The various clinical types of tinea infections in the 140 culture positive cases were tinea cruris (42 cases, 30%), tinea unguium (33 cases, 23.57%), tinea corporis (30 cases, 21.43%), tinea buttocks (15 cases, 10.71%), tinea pedis (10 cases, 7.14%), tinea manuum (5 cases, 3.57%), tinea capitis (2 cases, 1.43%), tinea barbae (2 cases, 1.43%) and tinea faciei (1 case, 0.7%). This is also in

confirmity with other published studies.[2]

The majority of our patients (23) were active workers [farmers(7), drivers (3), labourers (5) and semiskilled workers (8)] doing strenuous physical work leading to profuse sweating. Most of our patients were wearing tight and synthetic clothes which caused more warmth and moisture of the body. These factors made the body surface suitable for the growth of dermatophytes and led to the high incidence of tinea cruris and tinea corporis cases. The high incidence of tinea unguium in our study might be due to the trauma inflicted to the nails as a result of hard physical work and habit of walking and working barefooted.

S Tandon, S P Dewan, U Mohan,
Amarjit Kaur, S K Malhotra
Amritsar

References

1. Ranganathan S, Menon T, Sentamil Selvi G, Kamalam A. Effect of socio-economic status on the prevalence of dermatophytosis in Madras. Ind J Dermatol Venereol Leprol 1995; 61: 16-8.
2. Karmakar S, Kalla G, Joshi KR, Karmakar S. Dermatophytoses in a desert district of Western Rajasthan. Ind J Dermatol Venereol Leprol 1995; 61:280-3.

CUTANEOUS DRUG REACTIONS

To the Editor,

A clinical study of cutaneous reaction was carried out at B J Medical College and Civil Hospital, Ahmedabad, for 1 year duration. Out of total 12,500 patients, cutaneous drug reaction was present in 200 cases (1.6%). Out of 200 cases 106 were male and 94 were female. Age was ranging from 1 year to 85 years. Mean age was 40.7 years. With the help of clinical history, physical examination and laboratory investigations to rule out any systemic disease an attempt was made to establish offending drug in each case, in few cases of fixed drug eruption therapeutic chellange test was carried out for confirmation of diagnosis.

In present study, highest incidence noted was of fixed drug reaction in 54 (27%) patients. In males lesions were found of glans penis, extremities and lips, while in females they were more detected on lips, thigh and on face. Common offenders were sulpha group, analgesics and paracetamol.[1] Urticaria was present in 48 (24.0%) cases, erythema multiforme in 27 (13.5%), monomorphic acne in 15 (7.5%), lichenoid rash, erythema multiforme rash in 8(4.0%), S J syndrome in 8 (4.0%), angio-oedema in 9 (4.5%), purpura in 4 (2.0%) patients, pigmentation and maculopapular rash in 3 patients each. Pityriaris rosea like rash, striae atrophicans and exfoliative dermatitis in 2 patients each, while anaphylactic shock and gingival hyperplasia and toxic epidermal necrolysis in one patient each, were present. Main offending drugs were analgesics and antipyretic (94 patients), antibiotics (51 patients), antituberculous (11 patients), steroids (8 patients), anti-convulsants (6 patients), anti-malarials (6 patients), anthelminthic (4 patients), anti-leprosy (3 patients), hormones (2 patients) and others 15 patients. In the present study, maculopapular rash was found following ciprofloxacin and cephalexin in one patient each.

In the present study, analgesics, anti-inflammatory, antipyratics and antibiotics remain the main culprit and clinical pattern was comparable to the previous study by Hanumanthappa.[2] Unfortunately these drugs are available widely without physician's advice and are cheaper and have proved hazardous to the patients. 27.5% of cases were presented due to self-medication. Hence patients should be advised regarding hazards of