sporotrichosis.[2,3] We report one such case of sporotrichoid mycobacteriosis.

A 37-year-old serving soldier presented with complaints of multiple nodules over right forearm of 6 months duration, appearing 3 weeks following trauma to right index finger. He had received pefloxacin therapy for a month, 3 months prior to presentation resulting in partial and temporary resolution of skin lesion. His trade involved grooming horses with history of frequent contact with mud and water. No significant past or family history was elicited.

General, physical and systemic examination revealed no abnormality. Dermatological examination revealed multiple, crusted erythematous mildly tender and indurated nodules and plaques varying in size from 0.5 to 3.0 cm in diameter in a linear distribution over extensor aspect of right forearm (Fig. 1). No lymphatic cords or regional lymph nodes were palpable.

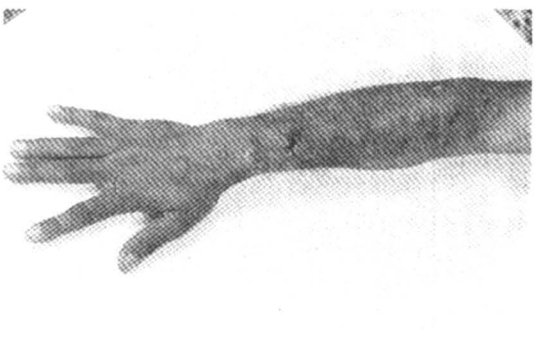

Fig. 1. Sporotrichoid skin lesions over right forearm.

Routine haemogram, urinalysis, blood sugar, LFT and serum ceratinine were within normal limits, ESR was 15mm/1st hour, Mantoux test was positive (16mm). Blood STS and ELISA for HIV were nonreactive. Skin biopsy revealed dense mononuclear infiltrate in upper dermis with few Langhans type of giant cells. No AFB, fungus or LD bodies were seen. Cultures for fungus, *Mycobacterium tuberculosis* and atypical mycobacteria showed no growth. Complete resolution of skin lesions was evident after 3 months of minocycline therapy, which is efficaceous in atypical mycobacterial infections.[4]

Appearance of lesions in a sporotrichoid pattern following trauma, histopathological features, and response to minocycline therapy in a person coming in frequent contact with mud and water is suggestive of atypical mycobacterial *(M marinum)* infection in this case. Failure to culture organism could be due to pefloxacin therapy received prior to presentation, as quinolones are documented to have activity against atypical mycobacteria.[5]

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References

1. Huminer D, Pitlik SD, Block C, et al. Aquarium-borne *Mycobacterium marinum* skin infection. Arch Dermatol 1986 ; 122 :698-703.
2. Dickey RF. Sporotrichoid mycobacteriosis caused by *M marinum* (balnei). Arch Dermatol 1968 ; 98 : 385-91.
3. Owens DW, McBride ME. Sporotrichoid cutaneous infection with *Mycobacterium kansasii*. Arch Dermatol 1969 ; 100 : 54-8.
4. Loria PR. Minocycline hydrochloride teratment for atypical acid-fast infection. Arch Dermatol 1976; 517-9.
5. Quinolone antibacterials. An update on their pharmacology and therapeutic use. Drugs 1994 ; 47 : 877.

SNEDDON-WILKINSON DISEASE

To the Editor,

Please refer to the article 'Sneddon-Wilkinson disease and arthritis' by S K Bose published in the Journal (1995 ; 61 : 231-2). I would like to share few of my observations on this disease.

Sneddon-Wilkinson disease (SWD) is no

doubt rare, yet quite a number of cases are seen in the dermatology clinic of a referral hospital like ours. Recently we had a female patient aged 40 years presenting with the classical bilateral symmetrical lesions of SWD on flanks, trunk and limbs. The lesion were present on the periphery of a diffuse erythema. The older lesions were replaced by sheets of desquamation. Patient was a known case of bronchial asthma for the last 20 years. Biochemical investigations were within normal limits. Repeated cultures from the pustules were sterile. Histopathology revealed a subcorneal bulla containing neutrophils and a few eosinophils. No definite acantholytic cells were seen. Basal layer was intact. Dermis showed few dilated blood vessels which were surrounded by neutrophils, eosinophils and few mononuclear cells.

Two important findings recorded in this case were :

(1) Crops of lesions were preceded by severe burning, pain and tenderness of the affected areas of the skin.

(2) Lesions were found over palms and soles.

Mild to moderate itching is present in most of the cases but features like burning and pain are poorly documented in the literature,[1] palms and soles are rarely involved in this disease as was seen in our case.[2,3]

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References

1. Mittal RR, Singla A, Gill SS.Subcorneal pustular dermatosis during summer months. Ind J Dermatol Venereol Leprol 1993 ; 59 : 288-9.
2. Haber H, Wells GC. Subcorneal pustular dermatosis of the soles. Br J Dermatol 1959 ; 71: 253-5.
3. Hellier FF. Generalized pustular bacterid: Its relationship to pustular dermatosis of Sneddon and Wilkinson. Br J Dermatol 1956 ; 68 : 395-9.

PENTOXIPHYLLINE IN CONTACT HYPERSENSITIVITY REACTIONS

To the Editor,

Contact hypersensitivity reactions (CHR) are very common in day to day dermatological practice. Treatment is difficult and recurrence is common. Recently pentoxiphylline (PTX) has been tried for treating CHR.[1,2]

Twenty five cases of CHR due to air borne contact dermatitis (ABCD) *[Parthenium hysterophorus]*, nickel allergy, microbial ides eruption, and cement allergy were selected for the PTX trial between October 1994 to October 1995. All had short courses of systemic steroids for the past 1-2 years. Six cases of ABCD (5 males and 1 female) presented with involvement of face, neck, dorsa of hand, cubital and popliteal fosae and other exposed areas depending on the type of work. All had previous patch test with leaf extract positive. Five cases of nickel allergy (3 females and 2 males) had patch test positive and the sites of involvement were neck, wrist, dorsum of foot, suprapubic area, back and tips of fingers. Six cases of microbial ides eruption (5 males and 1 female) with lesions affecting sites of trauma, scratch or mosquito bites ie extremities, ear, scalp, leg and palms. Eight cases of cement allergy with positive patch test and all males presented either as air borne pattern, or hand and foot dermatitis affecting palm, wrist and arm, foot, dorsum of foot and lower leg. All the patients had come during the flare up of the CHR and were put on a single protocol ie, 20mg for prednisolone daily for 7 days followed by 10mg for 7 days and 10mg alternative days along with pentoxiphylline [PTX] 400mg thrice daily for 15 days. After