coloured grouped soft non-tender nodules varying in size from 0.5-2 cm, seen on the left hip. There was no systemic involvement.

A provisional differential diagnosis of xanthoma or soft papilloma was made. Biopsy was taken from one of the nodules. Histopathological examination revealed island of fat cells embedded in the collagen bundles of the dermis, surrounding the dermal blood vessels and almost extending upto the epidermis (Fig.1).

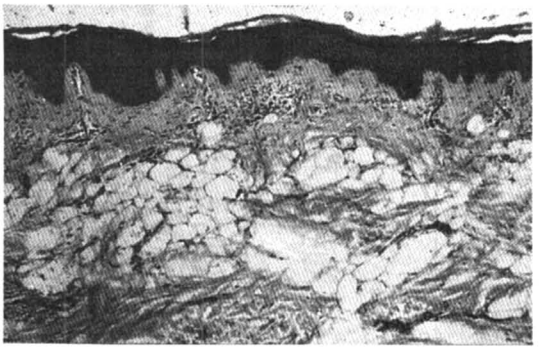

Fig. 1. Naevus lipomatoides cutaneus superficialis.

NLCS is a developmental anomaly. Though no sex predilection was mentioned earlier in the literature most of the cases including our patient were females.[3,4] There are two clinical forms, the one with zonal distribution occurs on the buttocks and presents from birth or childhood and the other domed or sessile papule beginning later in life and also occurring on the limbs.[5] The histopathology of this condition is characteristic. There is predominantly dermal collections of adipose tissue. Similar findings may also be seen with intradermal melanocytic naevi and Goltz syndrome both of which may be easily distinguished clinically from NLCS.[2] The lipocytes seen in the dermis are found to be immature and are postulated to arise from the pericytes as these are closely associated with dermal capillaries.[2] Comedo like plugs, cafe au lait spots, hypopigmented macules and ulceration over the lesions have all been described in a few cases, these were not observed in our patient.[5]

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MYCOLOGICAL ASPECTS OF DERMATOMYCOSIS IN YAVATMAL (MAHARASHTRA)

To the Editor,

Dermatomycosis is by far the most common fungal disease in human beings. Though various species of dermatophytes produce clinically characteristic lesions, a single species may produce variety of lesions depending upon site of infection. Infection is also produced by species of candida and a number of opportunistic fungi.

A total 112 clinically suspected cases of dermatomycosis were studied. Fungal species were identified by taking skin scraping and on the basis of cultural characteristics by standard mycological techniques.

Out of 112 clinically diagnosed cases of

dermatomycosis, 37 (33.33%) were positive for fungal isolates. Most common clinical diagnosis was tinea pedis (31-27.67%) while tinea manuum was diagnosed in 9 (8.03%) cases.

The commonest fungus isolated was *Trichophyton rubrum* (17-15.17%) followed by *T. mentagrophytes* (15-13.39%) and *Epidermophyton floccosum* (12-10.71%), other fungi isolated were *Candida albicans* (8-7.14%) and *Trichosporon* (3-2.67%).

In the present study tinea pedis was the predominant clinical type of dermatomycosis. Tinea corporis has been documented as the predominant clinical type in other studies.[1] Barefooted walking and working in fields may probably be related to the high incidence of tinea pedis in this rural area.

Trichophyton rubrum was found to be the main aetiological agent responsible for dermatomycosis in this area (15.17%). This is in confirmity with other published reports.[2] *Epidermophyton floccosum* has also been isolated frequently in the present study (10.71%). The isolation of this fungus has been variously reported as 12.04%[1] and 32.28%[3] in other studies. *Trichosporon* was isolated from three cases and *Candida albicans* from 8 cases. These are opportunistic nondermatophyte fungi. Such fungi are normally commensals, saprobes or plant pathogens. Their isolation in culture is not in itself a proof of pathogenicity, however, in the present study this fungus was repeatedly isolated from patients. This may point towards their suspected potentially pathogenic role as an opportunistic nondermatomycotic fungi.

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CHROMOBLASTOMYCOSIS

To the Editor,

We read with interest the recent article on chromoblastomycosis.[1] Chromoblastomycosis when localized to the skin can be managed by surgical means. Variable results are seen after cryosurgery.[2]

We treated a confirmed case of chromoblastomycosis with a single lesion on the leg of size 6x6 cm with two freeze cycles of 10 seconds each using liquid nitrogen. There was blistering, crusting and oedema which lasted for 2 weeks. At the end of 1 month there was complete healing with depigmentation.

Another case with a single plaque measuring 5x6 cm on the lower leg was similarly treated by cryotherapy. As it was not successful we excised the lesion using CO2 laser in a continuous cutting mode with 10-15 watts. The laser wound healed in about 6 months. There has been no relapse.

As disseminated infection is uncommon in chromoblastomycosis, we wonder whether HIV testing was done for the patient reported.[1]

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