LETTERS TO THE EDITOR

POST-KALA-AZAR DERMAL LEISHMANIASIS WITH ATYPICAL PRESENTATION.

To the Editor,

Post-kala-azar dermal leishmaniasis (PKDL) is a distinct clinical entity which occurs 1-6 years after an attack of visceral leishmaniasis. Three main types of lesions have been described: hypopigmented macules, which may be pin point to 1 cm and may sometimes coalesce; erythematous butterfly rash on the face; and infiltrative nodules.[1] We present a case of PKDL who had extensive hypopigmented macules.

An 18-year-old boy presented with infiltrated skin coloured nodules of varying sizes over central part of face trunk, upper and lower extremities. Many of the lesions on the lower trunk and thighs had coalesced to form large hypopigmented macules and in lower extremities the lesions covered the whole limb. There was history suggestive of kala-azar 8 years back for which the patient had been adequately treated. Skin smear from infiltrated nodule was positive for *Leishmania donovani* bodies on staining with giemsa. Histology from skin lesion, was consistent with post-kala-azar dermal leishmaniasis. Routine hematological investigations, the liver, renal function tests and ultrasonography of abdomen were within normal limits.

The hypopigmented lesions of PKDL are usually pinpoint to 1 cm in size and may coalesce. We have seen several cases of PKDL with hypopigmented macules, but in none of the patients were the lesions so extensive. On reviewing the literature also we did not come across any reference of presence of extensive hypopigmented lesions in PKDL.

Rathi S, Khanna N, Pandhi RK,
New Delhi

Reference

1. Bryceson Adm, Hay RJ. Parasitic worms and protozoa, In: Textbook of Dermatology (Champion RN, Burton JL, Ebling FJG, eds). 5th edn. Oxford: Blackwell Scientific Publications 1992; 1251-63.

AUTOHAEMOTHERAPY IN CHRONIC URTICARIA

To the Editor,

Urticaria is characterised by transient erythematous or oedematous swelling of dermis or subcutaneous tissue.[1] It can be acute when it is of less than 2 months duration or it can be chronic if it lasts for more than 2 months.

Besides genetic predisposition many other factors are responsible for urticaria e.g., foods and preservatives, drugs like penicillin, salicylates etc, insect bites, emotional stress and internal diseases like anaemia, worm infestation etc. Many physical factors like heat, cold, water, sun exposure also promote urticaria like reactions. Some defects in the immune regulatory system can also lead to urticaria.

Different modalities are used for treatment of urticaria. Main line of treatment consists of treatment of the cause, if detectable, alongwith antihistaminics. But combination of both H_1 and H_2 blockers are helpful as they block the release of histamine at both H_1 and H_2 receptor sites. Corticosteroids are used in acute cases only. Mast cell stabilizing agents like sodium