LETTERS TO THE EDITOR

ATYPICAL SUBCORNEAL PUSTULAR DERMATOSIS

To the Editor,

A 43-year-old male presented with a minimally itchy diffuse erythematous maculopapular eruption on the trunk (lateral aspects of chest and abdomen), neck and proximal upper and lower limbs of two days duration. He had taken eight tablets of furazolidone and four tablets of levamisole for diarrhoea two days prior to the onset of lesions. Dermatological examination revealed diffuse erythematous maculopapular eruption with ill-defined margins on aforementioned areas with complete sparing of axillary and groin flexures. Face and mucous membranes were not involved. Patient was comfortable except for low grade fever. At this juncture there were no pustules and, with the history, possibility of drug eruption was high. A day later discrete flaccid vesicles were seen progressing to vesico-pustules with characteristic hypopyon formation. Gram stain of pus from pustules showed large number of neutrophils and no bacteria. Histopathology was consistent with clinical diagnosis of subcorneal pustular dermatosis (SCPD) and there was dramatic improvement with dapsone.

Six of the seven patients initially described by Sneddon and Wilkinson were women and mean age of onset was 54.8 years.[1] However younger cases have been described in India in males.[2,3]

The eruptions tend to coalesce and produce annular, circinate or bizarre patterns over mainly axillae, groins and sub-mammary regions, abdomen and flexor aspects of limbs.

The atypical features of the case described are: (a) Male sex, (b) Younger age of onset, (c) Sudden onset, (d) Low grade fever, (e) Sparing of flexures, and (f) Lack of annular or circinate lesions.

The features of SCPD as depicted by this case can easily mimick a drug eruption, erythema multiforme and acute generalised pustular psoriasis of Von Zumbusch. Therefore SCPD should from a differential diagnosis of every case of generalised pustular dermatosis irrespective of distribution of lesions till proved otherwise.

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References

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3. Singh G, Malik AK, Bharadwaj M, et al. Subcorneal pustular dermatosis. Ind J Dermatol Venereol Leprol 1995; 61: 67-8.

ONYCHOMADESIS IN STEVENS JOHNSON SYNDROME

To the Editor,

Loss or partial loss of the nail may result from a bullous eruption affecting the tips of the digits. Any drug that can induce bullae may cause nail changes or nail loss due to destruction of the nail matrix.[1] We report a case of onychomadesis and temporary shedding of the nails following Stevens-Johnson syndrome.

A 28-year-old male on treatment with antituberculous drugs (INH, rifampicin, thiacetazone) developed generalised pruritus, erythema and bullous eruptions. Bullae were seen over the trunk and extremities including the fingers and toes. Ocular involvement