follicular and parafollicular papules with a central keratotic plug. The cause of disease is not known but it may be associated with diabetes, chronic renal failure and hepatic dysfunction.[1,2] A case of Kyrle's disease is reported.

A 23-year-old man presented with slowly progressive mildly pruritic, painless, discrete polygonal, symmetrical hyperkeratotic papules of 0.5 cm to1.0 cm size on the extensors of upper limbs, lower limbs and on buttocks . In the centre of papules a cone-shaped keratotic plug was present which was readily removed by the help of curette.Routine examination of blood, urine and stool were within normal limits. Patient was not having diabetes mellitus, renal failure or hepatic dysfunction.The clinical diagnosis of Kyrle's disease was made which was subsequently confirmed by the histopathological examination by presence of hyperkeratosis and parakeratosis of epidermis and a keratinous mass seen penetrating the follicular wall at places with dermal infiltrate of predominantly lymphocytes.

It is thought that metabolic disorders associated with Kyrle's disease are somehow responsible for development of abnormal Keratinization and connective tissue changes,[3] but the actual mechanism may be different as in our case the Kyrle's disease was seen in otherwise healthy adult male.

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ATYPICAL SUBCORNEAL PUSTULAR DERMATOSIS

To the Editor,

A 43-year-old man presented with a minimally itchy diffuse erythematous maculopapular eruption on the lateral aspects of chest and abdomen, neck and proximal upper and lower limbs of two days duration. He had taken 8 tablets of furazolidone and 4 tablets of levamisole for diarrhoea two days prior to onset of the lesions. Dermatological examination revealed diffuse erythematous maculopapular eruption with ill-defined margins on afore-mentioned 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.[4]

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.

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DERMATOLOGISTS' VIEW OF WHO MDT REGIMEN

To the Editor

I read with great interest the letter written by Dr R Ganapati, Leprologist, Bombay in our journal 1995 Vol.61, titled "co-ordination in Leprosy elimination programme." He has highlighted the fact of Government of India in taking effective steps under NLEP to make MDT available to almost all identifiable patients in most part of our country. He has also mentioned that he is surprised to note that inspite of low endemicity reported (by Govt.), the dermatologists are encountering a large number of leprosy patients.

As a practising Dermatologist and as the leader of many skin camps conducted by Lion Dr TV Venkatesan Memorial Foundation and sponsored by Rotary, Lions International, etc., I would like to bring the following details.

In my consultations as well as in the Skin camps I have noticed lot of leprosy cases who have been administered MDT (mostly fixed duration). There the treatment is discontinued as per the guidelines of WHO. After a period of surveillence such cases have to resort to private treatment from dermatologists because they are not completely cured of the disease or got relapse. Hence the increase in the number of leprosy cases seen by dermatologists as stated by Dr Ganapati in his letter. Therefore I would like to mention that the treatment of leprosy cases should be continued till the complete inactivity of the disease by the Government agencies duly bringing it to the notice of WHO.

V Harshan
Madurai

ERYTHEMA ANNULARE CENTRIFUGUM RESPONDING TO DAPSONE

To the Editor,

A 47-year-old male reported with a mildly pruritic skin lesion over the right forearm of 2 weeks' duration. The lesion was an annular erythematous plaque, of about 2.5 cm in diameter, and had a raised border. Topical antifungals, and later topical steroids were given. After an initial response to topical clobetasol propionate 0.05%, the lesion started progressing and extending. New lesions with an annular configuration started appearing proximal to the initial lesion. The plaque was then biopsied and subjected to histopathological examination. The epidermis showed irregular atrophy with spongiosis and focal parakeratosis. There was a sharply demarcated perivascular infiltrate of lymphocytes in the dermis. Based on the histopathological diagnosis of Erythema Annulare Centrifugum, topical steroids (betamethasone dipropionate 0.05%) was continued, but with no effect. The lesions