This child has now been on a regimen of co-trimoxazole and dapsone for the past 5 years. He continues to develop occasional crusted lesions which heal rapidly. He has had no mucosal lesions while under review. It remains to be seen whether the disease will burn itself out or enter a more malignant phase necessitating aggressive therapy.

The majority of cases of herpetiform pemphigus have shown a closer relationship to pemphigus foliaceus than to pemphigus vulgaris. Most patients have been managed on sulphones with low to absent doses of steroids. One-third of a reported series required high dose immunosuppressive therapy as in pemphigus.[2]

The beneficial role of co-trimoxazole in controlling disease activity was noted incidentally. Probably the sulphamethoxazole part of the combination acts in a way similar to the well-know sulfapyridine. The synergisitc role of trimethoprim cannot be completely ruled out.

Sarojini et al[4] have reported a patient with dermatitis herpetiformis who was maintained on co-trimoxazole and gluten-free diet, when drug-induced peripheral neuropathy forced the withdrawal of dapsone.

Co-trimoxazole could probably be used as an adjunct in sulphone responsive dermatoses where an increase of sulphone dosage is limited by side effects.This, to our knowledge, is the youngest reported case of herpetiform pemphigus.

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References

1. Jablonska S, Chorzelski TP, Beutner EH, et al. Herpetiform pemphigus : A variable pattern of pemphigus. Int J Dermatol 1975; 14: 353-9.
2. Ingber A, Feuerman EJ. Pemphigus with characteristics of dermatitis herpetiformis - A long term follow-up of 5 patients. Int J Dermatol 1986; 25: 575-9.
3. Maciejowska E, Jablonska S, Chorzelski T. Is pemphigus herpetiformis an entity ? Int J Dermatol 1987; 26: 571-7.
4. Sarojini PA, Abraham S, Nair BKH. Dapsone-induced peripheral neuropathy. Ind J Dermatol Venereol Leprol 1988; 54: 207-8.

SCLEREDEMA ADULTORUM : REPORT OF TWO CASES

To the Editor,

Scleredema adultorum is a chronic skin disorder of unknown aetiology which manifests clinically as an acquired non-pitting symmetrical induration of the skin with a peculiar wooden-like consistency. Few cases have been reported in Indian literature.[1,2] We report our experience with two such cases.

Two male children aged 9 years and 11 months respectively presented with 10 and 15 days history of hardening of the skin starting from neck and extending to back, shoulders and arms with a preceding history of febrile episode. The skin was hard, woody and non-pitting without any overlying erythema, atrophic changes, or areas of hypo and hyperpigmentation. Systemic examination did not reveal any abnormality. Haemogram and blood biochemistry were normal. Skin biopsy revealed normal epidermis with markedly thickened collagen bundles in the dermis separated by clear spaces suggesting oedema. Both children were given low dose oral steroids for 2 weeks. The former remained unchanged whereas the latter had complete recovery at 2 months.

Scleredema is characterized b

widespread thickening of the skin seccondary to the accumulation of collagen and proteoglycans in the skin commonly affecting children or adolescents.[3] In approximately 65% of cases, there is preceding acute febrile illness. Sometimes, the condition may be associated with diabetes mellitus which has been termed as diabetic scleredema.[4] Systemic pathology in form of dysarthria, dysphagia, ocular involvement, pleural or pericardial effusion and reversible ECG changes may be present.[5] Prognosis is good with spontaneous resolution within 6 months to 2 years in majority of cases. Various treatment modalities have been used with equivocal results including oral steroids. In our experience, one patient did not show any improvement on steroids whereas the other had complete recovery.

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References

1. Deorari AK, Arora NK, Singhal P, Lata M, Kabra V. Scleredema in a child. Ind Pediatr 1986; 23: 560-3.
2. Kumar R, Agarwal PK, Wakhlu AK, Wakhlu I. Scleredema in a 6-week old baby. Ind Pediatr 1991; 28: 1195-7.
3. Tuffanelli DL. Scleredema. Med Clin North Am 1989; 73: 1173-8.
4. Krakowski A. Diabetic scleredema. Dermatologica 1973; 146: 193-5.
5. Carrington PR, Sanusi ID, Winder PR, Turk LL, Jones C, Millikan LE. Scleredema adultorum. Int J Dermatol 1984; 23: 514-27.