liver and severe impairment of hepatic functions is considered a contraindication to PUVA therapy.[2] We report a case of acute reversible hepatic toxicity by trimethoxy psoralen (trioxsalen).

A 45-year-old Hindu female presented with vitiligo extending to chest and legs. After complete evaluation and baseline investigations like haemogram, blood sugar and LFT, she was given trimethoxy psoralen as 10 mg orally daily and was advised exposure to sunlight after 2 hours. After 7 days she came back with loss of appetite, nausea, vomiting and icterus. Psoralen was stopped and LFT done. Bilirubin was 3 mg%, SGOT 58 IU and SGPT 110 IU. Serum alkaline phosphatase was 27.5 KA units. She was managed for acute liver dysfunction with diet and drugs. Three weeks follow-up investigations revealed normal serum bilirubin, SGOT/SGPT and serum alkaline phosphatase. Patient was asked to discontinue treatment for 2 months. This resulted in increase in vitiligenous lesions. On her insistence she was again put on trioxsalen therapy, but within 3 days she developed nausea, and vomiting followed by icterus. Her investigation revealed increased serum bilirubin levels, SGOT and SGPT were 62 and 132 IU, respectively. Serum alkaline phosphatase was 31 KA units. Trioxsalen was stopped. Presently she is under observation and requires alternate therapy for vitiligo.

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References

1. Pariser DM, Wyles RJ. Toxic hepatitis from oral methoxalen photochemotherapy. J Am Acad Dermatol 1980; 3: 248.
2. Wolf K, Honigsmann H. Clinical aspects of photochemotherapy. Pharmacol Ther 1981; 12: 381.

PRIMARY LOCALISED CUTANEOUS AMYLOIDOSIS

To the Editor,

It was interesting to learn about the effectiveness of colchicine in the treatment of primary cutaneous amyloidosis.[1] In the materials and methods the authors state, "Clinical features were so characteristic that other investigations for confirmation of diagnosis were not considered necessary".

Macular amyloidosis can, at best be suspected on clinical examination. It is not easy to differentiate it from other conditions such as lichen planus pigmentosus, frictional melanosis, ashy dermatosis and numerous other conditions which have an interface dermatitis as histopathological finding. Although I do not doubt the clinical ability of the authors, in my opinion amyloid should have atleast been detected by H & E (a difficult task) if not be special stains. I hope the authors publish another paper confirming the efficacy of the drug after establishing the diagnosis of primary cutaneous amyloidosis.

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Reference

1. Chakravarthy K, Chanda M. Role of colchicine in primary localised cutaneous amyloidosis Ind J Dermatol Venereol Leprol 1995 ; 61 : 268-9.

REPLY

To the Editor,

We thank Dr Srinivas for taking keen interest in our article. I am putting our clarification as follows :

1) We agree with Dr Srinivas that it is a difficult task to detect amyloid by H & E stain. Amyloid can often be recognised in H & E section provided that it is present in sufficiently large amount.[1] As it in not a confirmatory test

we were reluctant to perform the investigation.

2) Most reliable method for demonstration of amyliod is the study of Congo red stained section under polarised light.[1] Unfortunately we couldn't avail that advantage due to lack of facility.

3) We included only those cases of macular amyloidosis which were having typical clinical features at typical sites, with characteristic reticulated or rippling appearance etc. A few cases only may be confused with other disorders. Cases with even least doubt were not included in the study.

4) In this context, it will not be out of place to mention that in a study of cyclophosphamide therapy in lichen amyloidosis, Pasricha and Seetharam included patients 'having characteristic lesions'[2] without any biopsy.

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References

1. Lever WF, Lever GS. Histopathology of skin. Philadelphia : Lippincott, 1990: 452.
2. Pasricha JS, Seetharam KA. Low dose cyclophosphamide therapy in lichen amyloidosis. Ind J Dermatol Venereol Leprol 1987; 53 : 273-4.

ULCERATIVE LICHEN PLANUS OF THE FOOT

To the Editor,

Lichen planus (LP) is a common skin disorder of unknown aetiology having various morphological variants. Ulcerative and bullous forms are extremely rare and that mimicking granulomata are still rarer. These granulomatous forms often cause diagnostic problems unless they are associated with lesions of lichen planus elsewhere over the body. Ulcerative and bullous LP of the feet with permanent loss of toe nails alongwith cicatricial alopecia of the scalp[1] and ulcerative LP of the feet with serological findings of SLE[2] have been described. The ulcerative lesions are important because they can be a site for epitheliomatous transformation.[3]

A 40-year-old female patient had a big painful ulcer 2x2 cm on the ventral aspect of her left foot for 3 years. The ulcer was having a granulomatous base with irregular margins. She also had two hypertrophic lesions on either side of the ulcer. Toe nails were normal. After about 2 years she developed lesions in the buccal mucosa and lower lip that on examination showed white streaks forming lace-like pattern alongwith few violaceous patches characteristic of LP. From the association of these lesions with those of the foot, she was diagnosed as a case of ulcerative LP of the foot mimicking chronic granulomata. The diagnosis was confirmed with biopsy. She was given dapsone 50 mg tid along with topical corticosteroids. She showed dramatic response and the lesions healed within 3 months.

Ulcerative LP of the feet usually involves the toe nails causing their destruction and gradual shedding.[1] Patients have chronic, progressive, crippling, erosive and ulcerative lesions resulting in scarring and deformities.Our patient showed chronicity and progression but the toe nails were not involved and no epitheliomatous changes were seen. Dapsons has given good results in such cases as we have seen in our patient.

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References

1. Cram DL, Kierland RR, Winkleman RK. Ulcerative lichen peanus of feet. Arch Dermatol 1966; 93: 692-701.
2. Thorman J. Ulcerative lichen planus of feet.