as a case of hypothoyroidism.[4] The histopathological examination and dermatological examination were suggestive of the case being of macular amyloidosis. The association of hypothyroidism and macular amyloidosis has not been reported as a discrete case. The familial association of hereditary cutaneous lichen amyloidosis and MEN IIa (Multiple endocrine neoplasia IIa) have been described.[2] But the present case is a discrete case of hypothyroidism with macular amyloidosis.

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DERMATITIS HERPETIFORMIS INTOLERANT TO DAPSONE IN AIDS

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A 35-year-old man with AIDS and pulmonary tuberculosis presented with lesions suggestive of dermatitis herpetiformis and intolerance to dapsone. He was managed successfully with a combination of nicotinamide 200 mg/day and indomethacin 75 mg/day, topical steroids and gluten free diet.

Key Words : Dermatitis herpetiformis, Dapsone, AIDS

Introduction

Dermatitis herpetiformis is a chronic blistering skin disease, presumed to have an autoimmune etiology with associated gluten sensitive enteropathy. It is associated with thyroid disorders. Other autoimmune diseases (SLE, rheumatoid arthritis, Sjogren's syndrome, ulcerative colitis) are associated due to high frequency of HLA B8.[1] Raynaud's phenomenon, glomerulonephritis, vitiligo, diabetes mellitus and atopic dermatitis also occur more frequently in patients with dermatitis herpetiformis than in normal population.[2] Dermatitis herpetiformis is probably a new association of AIDS, hitherto undescribed.

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Case Report

A 35-year-old man diagnosed to have HIV infection with pulmonary tuberculosis presented with grouped, bilaterally symmetrical, intensely pruritic, excoriated papular and papulo-vesicular lesions over the posterior axillary folds, buttocks, extensor forearms, knees, shins and ankles. The lesions left behind hyperpigmentation and scarring on involution. There was mild hepatosplenomegaly and generalised, non tender, lymphadenopathy on systemic examination, and occasional episodes of diarrhoea.

Routine hemogram, urinalysis, blood sugar level were within normal limits. ELISA and Western Blot for HIV were strongly positive. Chest X-ray showed infiltrates suggestive of pulmonary tuberculosis. The patient refused

skin biopsy.

The patient was clinically diagnosed as suffering from dermatitis herpetiformis and put on 100mg/day dapsone along with gluten free diet. His itching stopped altogether by the 2nd day, and new lesions stopped appearing by the 3rd day. On the 4th day, however he developed a maculopapular, erythematous, photosensitive rash over face, nape and V-of neck, extensor forearms and hands suggestive of drug rash. Dapsone was stopped and he was put on a short course of steroids starting with prednisone (20mg daily) tapered over one week. By the time steroid was stopped the drug rash subsided completely, but a fresh crop of lesions of dermatitis herpetiformis developed over the extensor surfaces. However, his lesions were controlled by combination of nicotinamide 200mg/day and indomethacin 75mg/day besides topical steroids.

Discussion

Esteves and Brandao used DDS in the treatment of DH with excellent results.[3] New lesions ceased to appear and pruritus was relieved in 24-36 hours. On withdrawal of dapsone, there was exacerbation of lesions within 24-48 hours. This has been used by many as a diagnostic test,[2] as in this case also.

In resistant cases, Johnson and Binkley used nicotinic acid in doses upto 400mg/day to suppress lesions of dermatitis herpetiformis. The pyridine ring similar to that in sulphapyridine might be the reason for its effectiveness. Coriciatti and Maconi achieved recovery in 3 out of 4 patients of dermatitis herpetiformis with doses upto 150 mg/day of indomethacin.[3]

Peculiarities of our case were (1)unusual association with AIDS, hitherto unreported, to the best of our knowledge (2) intolerance to dapsone prevented us from using systemic steroids or colchicine to control itching for a prolonged peroid due to associated pulmonary tuberculosis and AIDS. (3) Control achieved with combination of nicotinamide and indomethacin orally and topical steroids, besides strict adherence to gluten free diet.

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