LETTERS TO THE EDITOR

CALCINOSIS UNIVERSALIS IN CHILDHOOD

To the Editor,

Calcinosis cutis is an idiopathic deposition of calcium phosphate (apatite) in the dermis and subcutaneous tissue[1] which occurs in two forms. The circumscribed form limited to extensor aspect of joints and finger tips and the universal form which is much more progressive with deposition of calcium in any part of the skin. Intermediary forms however do exist.[2] Calcinosis universalis in children has been rarely reported from India.[3,4]

A 12-year-old girl presented with multiple pea sized asymptomatic cutaneous swellings over both lower limbs of 2 years duration. Over 4 to 6 months they enlarged in size, became yellowish white and were mildly tender. Later some ruptured and discharged a chalky white material. The patient denied any history of fever, joint pains, weakness or pain in the muscles around shoulder and hip, pain or bluish discolouration of extremities, chest pain or respiratory distress. There was no family history of a similar illness.

Her general physical and systemic examinations were normal. Cutaneous examination showed multiple cutaneous and subcutaneous nodules 0.5 to 2.5 cm in size in a bilateral symmetrical distribution over both ankles, shin, buttocks and sides of the legs. The lesions were yellowish white in colour with minimal perilesional erythema, firm in consistency and not fixed to the underlying structures. A few had ulcerated. There was no facial erythema, oral ulceration, finger tip ulceration or scars, nail fold capillaries, sclerodactyly and telangiectasia. Raynaud's phenomena could not be elicited. Examination of the musculo-skeletal system did not reveal any abnormality.

Laboratory investigations revealed a normal haemogram, serum calcium, phosphate, uric acid and fasting blood sugar. Muscle enzymes aldolase and creatinine phosphokinase were also within normal limit. Antinuclear antibody, LE cell, rheumatoid factor, and C-reactive protein were negative. VDRL was non-reactive and serum complement 3 was normal. 24 hours urinary excretion of calcium, barium swallow, pulmonary function tests, chest X-ray and EKG were all normal. Radiography of limbs revealed multiple subcutaneous dense opacities over lower limbs corresponding to the clinical lesions.

Histopathology from one of the nodules on H & E section revealed a normal epidermis with multiple deep blue granules in the dermis, which were suggestive of calcium on Von Kossa's stain. There was a mild gaint cell reaction around the deposits along with chronic inflammatory cells and fibrosis. Degeneration of collagen was also seen at some places.

Normal serum biochemistry and absence of calcification in any other organ rules out the possibility of metastatic calcification in our patient. Also normal density and preserved architecture of the bones militates against the possibility of hyperparathyroidism. The patient denied taking excess of vitamin D preparations, milk or alkalis. The clinical examination, laboratory investigations, pulmonary function tests and radiography ruled out the possibility of any connective tissue disorder such as scleroderma or dermatomyositis. The classical clinical picture and histopathology with calcification in

subcutaneous tissue helped us to clinch the diagnosis.

The cause of deposition of calcium in idiopathic calcinosis is not known.[1] Mild degenerative changes in the connective tissue; lowered CO^2 tension in the tissues which reduces the solubility of calcium, may be the predisposing factors.

Disodium EDTA is reported to produce favourable results.[4] The efficacy of corticosteroids is doubtful. Surgical removal of painful nodular deposits may offer temporary relief. We gave our patient a low calcium diet which is often of great help specially if combined with cellulose phosphate. As the patient was lost to follow up, the ultimate outcome is not known. The prognosis however is generally poor.

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References

1. Black MM, Gawkrodyer DJ, Seymour CA, Weismann K. Metabolic and nutritional disorders. In: Champion RH, Burton JL, Ebling FJG, eds. Oxford: Blackwell Scientific Publication, 1993: 2295-381.
2. Cornelius CE, Jenenhouse A, Weber JC. Calcinosis cutis-metabolic, sweat, histochemical, X-ray diffraction and electron microscopic study. Arch Dermatol 1968; 98:219-29.
3. Khandelwal MK, Tiwari JC. Calcinosis cutis (report of two cases). Ind J Dermatol Venereol 1963; 29: 172-6. .
4. Shroff JC, Marquis L. Case report-calcinosis cutis (a review with a case report). Ind J Dermatol Venereol 1968;34: 197-200.

EXTENSIVE TINEA CORPORIS CAUSED BY *T VERRUCOSUM* IN A PATIENT OF HIV INFECTION

To the Editor,

A 30-year-old man residing in suburban Madras was referred to the Department of Dermatology, Madras Medical College, Madras, for the treatment of scaly, patchy skin lesions throughout the body suggestive of tinea infection. He was subsequently found to be seropositive for HIV. Skin scrapings were collected for direct microscopy and culture. KOH examination showed the presence of fungal hyphae and chlamydospores. Culture on Sabouraud's dextrose agar (SDA) was very slow growing with growth appearing after 60 days. The colony was slightly folded, heaped glabrous and grayish brown in colour. No pigmentation was observed on the reverse side of the colony. The colony morphology on SDA, enhanced growth with thiamine and inositol, rapid hydrolysis of casein were suggestive of *Trichophyton verrucosum.*

Lactophenol cotton blue preparation of the fungus grown on SDA showed distorted hyphae with sparse antler like branching and chlamydospores in chains. The fungus grown on enriched media showed tear shaped microconidia and rat-tail shaped macroconidia. The macroconidia had 3-5 cells and was shaped like a string bean. Microscopy confirmed the identity of the fungus as *Trichophyton verrucosum.*

Trichophyton verrucosum is more frequently associated with cattle ringworm disease. However, isolation of *Trichophyton verrucosum* from human ringworm disease has been reported from India.[1,2] Klokke et al[3] have reported the isolation of this species from human ringworm disease in South India. However, in previous reports, the infection was described to be erythematous, inflammatory, pustular, localized lesions which responded to treatment. In the present study we report the isolation of *Trichophyton verrucosum* from a case of extensive tinea corporis in a HIV+patient. The lesion was non-