SHIELD AS TOPICAL OINTMENT IN HERPES ZOSTER

To the Editor

It was really interesting to read the letter from Dr. Yogesh Agarwal published in our journal, July - Aug 97.

I would like to share our experience. We have been using lignocaine (5%) ointment routinely in treatment of herpes zoster cases for initial few days.[1] We avoid combination product keeping in mind the secondary infection and ACD[2] which steroid can precipitate. We also keep in mind to withdraw it as soon as possible so that the patient doesn't keep on using it for post herpetic neuralgia and we land up with another problem of ACD to lignocaine which it is known to cause.[3]

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References

1. The Practical Prescriber : Golwalla AF, 1990 (6th Ed) ; 52.

2. Wilkinson JD, Shaw S. Contact Dermatitis : Allergic, In : Textbook of Dermatology : Edited by R H Champion, J L Burton, A Burns, S M Briathnach, Blackwell Science Ltd. Oxford (6th Ed) 1998 ; 783.

3. Mark JG, Belsito DX, Leo VAD, et al. North American Control Dermatitis Group patch test results for detection of delayed type hypersensitivity to topical allergens, J Am Acad Dermatol 1998;911.

PUNCH GRAFTING IN VITILIGO

To the Editor

This is in reference to the article "punch grafting in vitiligo : Refinements and case selection" by Subodh Kumar Singh (IJDVL 1997, 63 :296 -300).

I want to add certain points in this regard.

1. The introductory sentence itself is somewhat confusing where it refers to the "complete disappearance of pigmentary cells in the basal layer of dermis and perifollicular epidermis, clearly there is a mix -up between "dermis" and "epidermis" .

2. The author has only included focal and segmental vitiligo in his study. Inclusion of other types of cutaneous achromia (eg. Vitiligo vulgaris, piebaldism, post-burn depigmentation etc.) could have made the study more broad based.

3. Duration of the disease varied from 1 to 19 years in the study but no mention was made about the period of disease stability. Before taking the operating option the clinician must ensure that the disease is inactive (i.e. the existing patches are not increasing in size, there is no new patch, and there is no Koebner phenomenon). In case of slightest doubt test grafting can be done.[1]

4. 2.5 -3mm punches were used in the study. When smaller punches are available use of larger punches could have been avoided easily. Falabella found 3 mm and even 2mm grafts more visible and scars more noticeable as compared to 1mm grafts.[2] He concluded that larger grafts left cobble stone appearance and smaller grafts are incapable of spreading favourable perigraft pigment spread. So he settled for a size in between, i.e., 1-2 mm.[2]

5. We have noticed in our studies that 2 mm punches can be used both in the donor and the recipient areas without any problem.[3, 4]

6. The chance of contact sensitisation to framycetin could be avoided by using sterile paraffin gauze.

7. Dressing can be removed after 5 days, because it takes 2-3 days for capillary linkage to occur and vascularisation of the graft.[5] In our experience even 3 days were sufficient for dressing removal from highly vascular areas, e.g. lips. We didn't feel the need for application of dressing for another 7 days, as suggested by the author.

8. The result section can be made more lucid with the use of tables and graphs in a study like this.

9. We have studied the AOR (appearance of repigmentation) time extensively in one of our studies in 110 cases . AOR ranged between 14 and 39 days, with an overall average being approximately 21.6 days.[6]

10. Regarding perigraft spread of pigment the observation of faster spread in patients between 10-25 years of age and in those with soft, thin, elastic, undamaged, dark skin is indeed interesting. MPS (Maximum pigment spread) was studied by us in 29 different regions of the body of 110 cases and was found to be varying between 0 to 10 mm, with an over all average of 5.5 mm (approx).

11. 'Local' steroid cream was used for the donor area, though the reason for this was not explained. Emollients are often sufficient.

12. Cobble stoning and variegated appearance was observed over eyelids, malar region, chin and dorsum of the hand by the author which was quite in contrary with our observation where we have found favourable pigment spread over exposed parts especially over forehead, eyelid, chin and less favourable outcome over covered or shadowed parts like groin, submandibular regions and areas over bony prominences like elbow, malleoli etc.[6,7] Dr. Singh should be congratulated for his study. But, unfortunately this has added nothing new to our existing knowledge on punch grafting in general , and " refinements and case selection" in particular. He has rightly concluded that still there is a dearth in our understanding of the factors controlling and modulating the pigment cell replenishment.

If the patients are selected properly and the procedures performed meticulously, punch grafting can bring relief to a large population of hopeless and frustrated patients.

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References

1. Falabella R, Arrunategui A, Barona MI, et al. The minigrafting test for vitiligo : detection of stable lesions for melanocyte transplantation. J Am Acad Dermatol 1995. 32 : 228 -232.

2. Falabella R. Repigmentation of stable leucoderma by autologous minigrafting. J Dermatol Surg Oncol 1986;12 :112-129.

3. Lahiri K, Sengupta SR. Treatment of stable and recalcitrant depigmented skin conditions by autologous punch grafting . Ind J Dermatol Venereol Leprol 1997 ; 63:11-14.

4. Malakar S Punch grafting . In : An Approach to Dermatosurgery. 1st edn. Calcutta : A Paul, 1996 : 44 -46.

5. Burge S, Rayment R . Simple skin surgery. 1st edn. London : Blackwell Scientific Publication, 1986; 71 - 84.

6. Lahiri K, Sengupta SR. A regionwise comparative study of post punch graft appearance of repigmentation (AOR) time in cutaneous achromia. Indian J Dermatol 1998; 43 : 13-15.

7. Lahiri K, Sengupta SR. A regionwise comparative study of the extent of post punch graft surgical repigmentation in cutaneous achromia. Indian J Dermatol Venereol Leprol. (Accepted for publication, Ref. No. 205/97).