leading to paresis/ paralysis of the muscles.

A 30-year-old woman presented with pain on the inner side of right arm and slight wasting of right arm and right hand for the last 6 months. She gave history of painful grouped vesicular lesions on the inner side of right arm. After the resolution of lesions she developed shooting pain off and on on the inner side of the right arm that was followed by wasting of muscles of lateral and inner compartments of right arm alongwith slight clawing of medial 2 fingers. There was no history of fever, any drug intake or any injection in the right arm. she gave history of chickenpox during childhood. There was no history of migration outside Punjab.

On examination, multiple, hypopigmented grouped round/oval macules were seen on the right arm along the distribution of segment C_8T_1 (ulnar nerve distribution). No other skin lesion was seen. Wasting of muscles of right arm and interossei muscles of right hand was visible. Slight clawing deformity of little and ring finger was appreciated. Cutaneous sensory impairment was present on these two fingers. No thickened nerves were palpable. She was diagnosed as a case of post herpetic neuralgia with involvement of ulnar nerve. Bhargava et al described deltoid nerve paresis following herpes zoster with dropping and flattening of shoulder after 3 months follow up.[1] Motor involvement in herpes zoster is rare. In our patient it seemed a permanent disability as she showed no improvement within 6 months of follow up. In our opinion, we can reduce the disfunctioning and disfigurement that results due to motor/ sensory involvement of the nerves, if we start oral as well as topical acyclovir from the very beginning especially in young patients.

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ANAEROBIC PEPTOSTREPTOCOCCAL POSITIVE CASE OF HIDRADENITIS SUPPURATIVA

To the Editor,

A 19-year old girl presented with painful recurrent abscesses in axillae and perineal region of 1 year duration. The abscess used to rupture and drain, resulting in healed sinus and scar formation. Routine investigations were normal. F N A C showed dense suppurative inflammation with macrophages, a few squamous and apocrine cells. Gram stain showed positive tiny cocci in chains. Culture yielded anaerobic peptostreptococcus. Thus the cytological diagnosis of hidradenitis suppurativa was made.

Hidradenitis suppurativa is a chronic recurrent painful suppurative and cicatricial disease. The sites of occurrence are axilla, groin, anogenital areas, periumbilical and areola. These lesions begin after puberty and are more common in women than men. Leach et al, in their study of 52 patients with axillary abscesses, isolated Staphylococcus aureus from 34, anaerobic bacteria from 12, skin flora from 5, while in one case the pus was sterile.[1] It is necessary to isolate and culture anaerobes from axillary hidradenitis since 25 % of the cases were anaerobic in this study.[1] The present case was treated with ampicillin and metronidazole and showed good response.

Flora D Lobo, Vatsala S Rao,
C V Raghuveer
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KLIPPEL - TRENAUNAY SYNDROME

To the Editor,

A one-year-old boy a product of consanguinous marriage, presented with an abnormally large left foot since birth. There was no positive family history of similar disease. There was grotesque enlargement of the left lower limb with increased length and girth. Hypertrophy of the left foot with macrodactyly and normal movements at the subtalar and ankle joints were seen. Single port-wine stain with irregular margins was present over the right lumbar region. There was no evidence of varicose veins, abnormal pulsations or bruit over the left lower limb.

Routine haemogram, urinalysis, liver enzymes estimation, serum calcium and phosphate levels and ultrasonography of abdomen were normal. There was nothing abnormal in X-rays of the skull and chest, while X-ray of left foot showed evidence of soft tissue overgrowth and increased transverse diameter of phalanges suggestive of macrolipomatosis dystrophy.

The association of varicose veins, soft tissue and bony hypertrophy, and cutaneous haemangioma of the port-wine variety confined to one extremity was first reported in 1900 by Klippel and Trenaunay.[1] However, not all patients have all the abnormalities of the triad.[2]

The interesting and unusual features of this rare case were the coincidental history of consanguinity in the parents, presence of a single port-wine stain on the contralateral side of the body away from the affected limb, absence of varicosity and bruit over the left lower limb, and associated macrodactyly, in addition to the bony and soft tissue hypertrophy of the left lower limb.

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Pune

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BLEPHAROCHALASIS

To the Editor,

A 25-year-old man gave a history of repeated transient attacks of painless swelling, of eyelids of both eyes since the age of 15 years. Such episodes progressively become more frequent with age. There was no history of similar disease in family members, or any preceding emotional or physically traumatic event. There was no evidence of eyelid trauma, infection, contact eczema, angioneurotic oedema, cutis laxa or lip swelling. Investigations for evidence of tracheobronchomegaly, goitre and renal disease were negative. Bilaterally symmetrical lid laxity, predominantly of the lower eyelids, with thinning, atrophy, wrinkling and prolapse of the orbital fat was present giving the patient an appearance of tiredness and premature aging.

Blepharochalasis is laxity of the eyelid skin due to a defect in the elastic tissue. It occurs in young people around puberty.[1] Its cause is unknown. Most cases are sporadic, but some pedigrees show autosomal dominant inheritance.[2] Many develop blepharochalasis after an emotionally or physically traumatic