# LETTERS TO THE EDITOR

## ALOPECIA AREATA AND XEROSIS IN DOWN'S SYNDROME

*To the Editor,*

A 4 years and 9 months old girl reported with the history of repeated respiratory tract infection. On examination she had typical mongol face and congenital heart disease (VSD) with left to right shunt. Skin examination showed dry skin all over the body with loss of hair on four places of scalp. Diagnosis of Down's syndrome was established by clinical finding and karyo typing chromosomal analysis.

Alopecia areata occurs in Down's syndrome in older children[1]. In our patient alopecia areata started when child was 11 months old.

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### Reference

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## SISTER MARY JOSEPH'S NODULE AS PRESENTING SIGN OF OVARIAN CARCINOMA

*To the Editor,*

Malignant tumours have the ability to grow at sites distant from the primary site of origin.The umbilicus is a characteristic site, especially from cancer of the stomach (Sister Mary Joseph's nodules).[1] A case of umbilical metastasis from ovarian carcinoma is reported here.

A female aged 40 years presented with lesions in the umbilicus since 4 months.Except history of menorrhagia, patient did not have any symptom of significance. On examination hard nodule with superficial erosion was found in umbilical area. Per abdominal examination revealed an irregular slightly mobile, hard mass arising from pelvis in the left iliac fossa. Pervaginal examination confirmed our findings of pelvic mass. Routine haematological examination showed anaemia. USG of the abdomen revealed findings suggestive of bilateral serocystoadenomatous ovarian carcinoma.

The so called Sister MaryJoseph's nodule is formed by localization of metastatic tumours to the umbilicus.Powell et al reviewed 85 cases of Sister Mary Joseph's nodule and found the most common primary sites to be stomach, large bowel, ovary and pancreas.[2]

Brustaman and Seltzer have reported seven cases of umbilical metastasis from gynaecologic malignancies.[3] Umbilical metastasis were the presenting symptoms in 18 out of 40 cases, and were a major diagnostic feature in 28 cases.[4]

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## KYRLE'S DISEASE

*To the Editor,*

Kyrle's disease is a rare disorder of keratinization, first described by Kyrle in 1916. It usually presents as multiple hyperkeratotic

follicular and parafollicular papules with a central keratotic plug. The cause of disease is not known but it may be associated with diabetes, chronic renal failure and hepatic dysfunction.[1,2] A case of Kyrle's disease is reported.

A 23-year-old man presented with slowly progressive mildly pruritic, painless, discrete polygonal, symmetrical hyperkeratotic papules of 0.5 cm to1.0 cm size on the extensors of upper limbs, lower limbs and on buttocks . In the centre of papules a cone-shaped keratotic plug was present which was readily removed by the help of curette.Routine examination of blood, urine and stool were within normal limits. Patient was not having diabetes mellitus, renal failure or hepatic dysfunction.The clinical diagnosis of Kyrle's disease was made which was subsequently confirmed by the histopathological examination by presence of hyperkeratosis and parakeratosis of epidermis and a keratinous mass seen penetrating the follicular wall at places with dermal infiltrate of predominantly lymphocytes.

It is thought that metabolic disorders associated with Kyrle's disease are somehow responsible for development of abnormal Keratinization and connective tissue changes,[3] but the actual mechanism may be different as in our case the Kyrle's disease was seen in otherwise healthy adult male.

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## References

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2. Constantine VS, Carter VH. Kyrle's disease-II. Histological finding in five cases and review of literature. Arch Dermatol 1968; 97:633-9.
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## ATYPICAL SUBCORNEAL PUSTULAR DERMATOSIS

*To the Editor,*

A 43-year-old man presented with a minimally itchy diffuse erythematous maculopapular eruption on the lateral aspects of chest and abdomen, neck and proximal upper and lower limbs of two days duration. He had taken 8 tablets of furazolidone and 4 tablets of levamisole for diarrhoea two days prior to onset of the lesions. Dermatological examination revealed diffuse erythematous maculopapular eruption with ill-defined margins on afore-mentioned areas with complete sparing of axillary and groin flexures. Face and mucous membranes were not involved. Patient was comfortable except for low grade fever. At this juncture there were no pustules and, with the history, possibility of drug eruption was high. A day later discrete flaccid vesicles were seen progressing to vesico-pustules with characteristic hypopyon formation. Gram stain of pus from pustules showed large number of neutrophils and no bacteria. Histopathology was consistent with clinical diagnosis of subcorneal pustular dermatosis (SCPD) and there was dramatic improvement with dapsone.

Six of the seven patients initially described by Sneddon and Wilkinson were women and mean age of onset was 54.8 years.[1] However younger cases have been described in India in males.[2,3] The eruptions tend to coalesce and produce annular, circinate or bizarre patterns over mainly axillae, groins and sub-mammary regions, abdomen and flexor aspects of limbs.[4]

The atypical features of the case