cromoglycate, terbutaline and ketotifen are also used. Tranquilizers are of help in cases with psychogenic component. Topically soothing agents like calamine are used. But none of these modalities has given satisfactory results. Autohaemotherapy is being evaluated for treatment in chronic urticaria.

We have tried autohaemotherapy in 50 cases of chronic urticaria. Every possible cause was ruled out in all the cases. Investigations were within normal limits except for more than 7% eosinophils in every case. 50 patients were given autohaemotherapy and 50 were treated by other modalities. The procedure consisted of taking blood from patient's cubital vein and directly injecting it into gluteus muscle of same patient without mixing the blood with any anticoagulant. During first week 2 ml blood was injected biweekly and then 5 ml biweekly in second week and in the third week 10 ml blood was given biweekly.[2]

We found that patients responded better to autohaemotherapy than to any other modalities. Itching subsided quickly, duration of weal was also decreased and interval between two episodes of the disease was increased from days to weeks.

Due to lack of satisfactory treatment and good results of autohaemotherapy it should be considered in the treatment of chronic urticaria but it needs further trials.

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SCLEREDEMA

To the Editor,

An 8-year-old boy presented with sudden onset of thickened, taut skin over the neck, shoulders rapidly spreading to involve the face, upper trunk, arms and upper abdomen preceded with mild prodrome. Increased pigmentation was seen over affected areas with puffiness of face and inability to open the mouth. The skin was bound down, non-tender with non-pitting oedema. No clear line of demarcation could be detected between affected and unaffected skin. Distal upper extremities and lower limbs were remarkably free. The patient had pyoderma one month ago. There was no history of fever, joint pain or Raynaud's phenomenon in the past or present. Other systems were not involved. Routine haematological examination and urinalysis were within normal limits except ESR which was raised. ASO titre was high (250 Todd units/ml). Tests for Rheumatoid factor and LE cell phenomenon were negative. ECG and chest X-ray did not reveal any abnormality. Histopathology of biopsy specimen from scapular region stained with H and E showed characteristic findings[1] of scleredema. No specific treatment was given but the child showed spontaneous improvement from 3 weeks onwards and after 6 months there were no residual sign of disease. The characteristic clinical course, histopathological findings were somewhat similar to other documented cases of scleredema.[1,2] In view of the sudden onset, preceding history of pyoderma and raised ASO titre a streptococcal hypersensitivity reaction is suggested.

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DEPRESSION MANIFESTING AS URTICARIA

To the Editor,

This letter is with reference to an interesting article entitled 'depression manifesting as urticaria' published in the Journal (1993;59:41-2)

From the article it envisages that the three patients of chronic urticaria were only partially controlled with antihistaminics and corticosteroids. It is not clear from the article that in what kind of depression the patients were i.e. exogenous or endogenous, as the term moderate to severe depression is not conceivable. It may be possible that the depression was only secondary to chronic urticaria i.e. exogenous depression in which case tricyclic antidepressants are not indicated.

Also it is not clear from the article that after how much period the patient first showed improvement after the institution of antidepressant therapy with imipramine. If it was due to antidepressant action (taking that the patients were in endogenous depression) it would take 3-5 weeks or more before the onset of action. But if the improvement occurred earlier (not specified except in the second case who showed immediate improvement after restarting the drugs which she had stopped for two weeks) then there is an immense possibility that the improvement could have taken place because of imipremines H1 and H2 receptor blocking action instead of its antidepressant action, as this drug is quite a potent blocker of the aforementioned receptors.[1]

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Reference

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KISSING LUPUS VULGARIS

To the Editor,

A 19-year-old male presented with chronic ulcers over both buttocks of 5 months duration. Initially, he noted a small pea-sized raised eruption over the left buttock near midline which 2 weeks later spontaneously ulcerated, discharging seropurulent material. A few weeks latter, patient noticed similar swelling on the right buttock kissing the previous one. There was no history indicative of systemic involvement.

The skin of both gluteal regions was showing oblong obliquely placed plaques. they were brownish red, hyperkeratotic and indurated. Hyperkeratosis was marked at the margins especially over their inner ends. Scarring and pigmentation was apparent in the centres of the plaques. The skin adjacent to the medial ends of the plaques in the natal cleft was not involved. Diascopy was unrewarding. BCG vaccination scar was absent.

Total and differential count and blood sedimentation rate were within normal limits and so also was the skiagram of the chest and lumbosacral spine. Ziehl-Neelson-stained