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Aggravation of preexisting dermatosis with *Aloe vera*

Sir,

A 65-year-old man presented with recurrent generalized itching since 1 year. Examination revealed lichenified skin over the face and extensors of both extremities. He gave a history of rubbing the pulp of *Aloe vera* leaves on to his lesions whenever his itching worsened. Clinically, we suspected allergic contact dermatitis, possibly aggravated with *Aloe vera.* He was patch tested with the plant series by CODFI, which included parthenium 0.5%, xanthium 0.5%, chrysanthemum 0.5%, control and pulp of *Aloe vera,* and the results were interpreted as recommended by ICDRG. He tested positive to *Aloe vera* on day 2 and day 3. One of the authors (CRS) tested negative to the pulp, thus ruling out irritant dermatitis.

Allergic contact dermatitis to *Aloe vera* has been reported earlier.[1,2] The gelatinous material inside the leaf of *Aloe vera* has been recommended from ancient times for the alleviation of inflammatory changes in the skin.[3] More recently it has been advocated in the treatment of radiodermatitis and leg ulcers.[4] It is a common ingredient in numerous topical moisturizers (e.g. Elovera, Sofderm, Dewderm). Aloe consists of a variable mixture of aloin, aloemodin and other substances.[3] Aloin is an anthraquinone that may be regarded as a potential sensitizer.[3]

This report highlights the fact that even commonly used, relatively safe medications can occasionally cause sensitivity.

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Familial woolly hair in three generations

Sir,

I read the article "Familial woolly hair" by Prasad et al (Indian J Dermatol Venereol Leprol 2002;68:157) and wish to report a similar case, present in three generations of a family.

A 5-year-old non-atopic boy born of a consanguineous marriage was referred by the Pediatrics Department for evaluation of abnormal hair over the scalp since birth. There were no delayed milestones, physical or mental retardation or photosensitivity. Examination revealed short, tightly coiled, thin, dry, poorly pigmented, brittle hair over the scalp. The eyebrows were sparse but the eyelashes were normal. The palms and soles were not involved and the nails, teeth and genitalia were normal. His systemic examination was normal. There was no ocular or skeletal involvement. The patient's family pedigree showed similar involvement in three generations. There was inbreeding within the family.

Routine hematological and urinary examinations were normal. Blood VDRL, liver function tests, blood urea, serum creatinine, and blood sugar were normal. Light microscopic examination of the hair was normal. Electron microscopic examination could not be done for the want of this facility.

Woolly hair refers to tightly coiled hair covering the whole scalp or part of it, in a non-negroid individual.[1] Four types have been described:[2] 1) Hereditary woolly hair, 2) Familial woolly hair, 3) Symmetrical

circumscribed allotrichia, and 4) Woolly hair nevus. Woolly hair in association with keratosis pilaris atrophicans and cataract,[1] keratosis pilaris and curling of eyelashes,[3] palmoplantar keratoderma and cardiac involvement[4] have been reported.

Inbreeding within the family, presence of woolly hair in children born consanguineously, and the absence of this abnormality in the parents of affected children, suggestive of autosomal recessive inheritance, were points favoring the diagnosis of familial woolly hair. However, there were no associated cutaneous or systemic abnormalities in them. Cases of familial woolly hair are rarely reported and its occurrence in three generations of a family is still rarer.

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Chronic pelvic inflammatory disease and melasma in women

Sir,

Melasma is a photosensitive dermatosis of the sun-exposed areas of the face, characterized by light or gray brown pigmentation.[1] The exact cause of this dermatosis is not known in a large proportion of cases. The majority of cases are considered to arise in pregnancy[2] and in patients on oral contraceptives.[3] The infrequency of melasma in post-menopausal women on oestrogen replacement therapy suggests that it alone is not the causative factor, although some of the patients on combination therapy with progesterone and oestrogen have been found to develop melasma.[1] Though, some of the patients of idiopathic melasma had mild ovarian dysfunction[4], plasma concentration of β-melanocytic-stimulating-hormone in these patients and those on oral contraceptives have been found to be normal.[4,5] Genetic factors, thyroid dysfunction, cosmetics, phototoxic and antiseizure drugs have been implicated as other etiological factors.[1] It was further shown by the study of Sawhney[6] at high altitudes, where the levels of UVB were 250% of those at sea level at mid noon, that melasma develops as a protective mechanism to either high levels of UVB or in those with photosensitive skin. Although it is seen predominantly in females, women even at high altitudes had a slightly higher incidence of melasma than men.[6] The question that needs to be answered is what makes the skin in females more photosensitive than in males. This study was thus designed to go into the details of the history and examination in cases of melasma in females.

A study was conducted in 127 cases of melasma in women who reported to the dermatology OPD from Jan to Mar 2003, to find out the possible underlying cause of this photosensitive disorder. The average age of the patients was 34.29 (range 19-65) years and the average duration of melasma was 45.72 (range 1-204) months. Seventy (55.12%) patients had received some form of topical therapy from a qualified dermatologist for an average duration of 4.28 (range 1-24) months with temporary/incomplete relief.

Seventy four (60.63%) patients of melasma had evidence of chronic pelvic inflammatory disease (PID), in 35 (27.56%) of them in association with Fitz-Hugh-Curtis (FHC) syndrome. The average age and duration of melasma in patients with FHC syndrome, PID alone and only melasma with no clinical evidence of PID was 37.06 (SD 8.49) and 48.77 (SD 57.56); 34.77 (SD 7.54) and 43.64 (SD 43.91); and 32.06 (SD 7.56) years and 38.79 (SD 38.00) months respectively. Patients with melasma with FHC syndrome were found to be significantly older ($p < 0.05$) than those with only melasma. Three (2.36%) had Reiter's syndrome, 2 (1.57%) conjugal melasma and 1 (0.79%) each had primary and secondary infertility.