

Letters to the Editor

PSORIASIS AND DIABETES IN IDENTICAL TWINS

To the Editor

We read with interest the article on "psoriasis in identical twins....." by Singh et al.¹ To share our similar experience in this regard, we would like to report a pair of identical twins both presenting with diabetes mellitus and psoriasis vulgaris of similar pattern.

A pair of identical male twins, each aged 41 years, and both being farmers by occupation, presented with erythematous plaques over the scalp, elbows, knees and the lower back of 10 and 8 years duration in the elder and younger brothers respectively. The lesions were covered with thick, white and easily detachable scales. The lesions were asymptomatic, and history of exacerbation during winter was present. Both the patients also had diabetes mellitus with FBS/PPBS of 260/438mg% and 273/525 mg% respectively. They did not have any other problems except for mild hypertension (BP-140/100mmHg) in the elder brother. As the patients were from a far off place, all their family members could not be examined. However as per the history, none of the other family mem-

bers had either diabetes mellitus or psoriasis. Histopathological examination was not done as the clinical lesions were classical.

The role of genetic factors in the etiology of psoriasis has been confirmed by studies on twins with approximately 70% concordance in monozygotes and 20% in dizygotes.² Still, concordance of less than 100% highlights the role of environmental factors in this regard acting in concert with a genetic susceptibility to produce the psoriatic phenotype.

Another interesting feature in our patients was the concurrent presence of diabetes in both the patients in addition to psoriasis. Diabetes is known to be associated with psoriasis.^{3,4} But the presence of both diabetes and psoriasis in twins is rather unusual and to our knowledge has not been highlighted. Both diabetes and psoriasis having multifactorial etiology and with genetic factors playing an important role, it is worthwhile to investigate for potential loci for a gene or genes of psoriasis and diabetes and to establish the possible link between the two, though they are unlikely to be monogenic.

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MANAGEMENT OF HERPES ZOSTER

To the Editor

The role of corticosteroids in herpes zoster is excellently highlighted in the recently introduced 'View point' column in the *Ind J Dermatol Venereol and Leprol* 1996; 62: 193. The editors ought to be congratulated on initiating this. It would provide a platform for both new and old colleagues in our field to express their own views and experiences on the topic covered. We as a rule prescribe corticosteroids in doses upto 40mg of prednisolone a day in all patients of herpes zoster (except ophthalmic zoster) upto 40 years of age provided they are not diabetics or immunocompromised. For patients above

40 years of age, if they report within 48-72 hours, acyclovir 800mg 5 times a day for 5-7 days is prescribed. For the remaining patients, the treatment is largely symptomatic. Five percent xylocaine applied topically relieves the pain, burning and tingling and so far fortunately we have not observed any contact sensitivity to it. As far as post-herpetic neuralgia is concerned, no doubt it is refractory to treatment, but it is self-limiting and the pain disappears over a period of about an year. As is well known, the incidence and severity of post herpetic neuralgia increases with age and it is more in patients who develop ophthalmic zoster. These are the patients who constitute a special group. Here one has to be extremely careful and vigilant and patients with ophthalmic zoster are better managed by ophthalmologists. In our experience, carbamazepine 100mg three times a day, topical capsaicin and oral doxepin 25mg at bed time are quite effective. Though there has recently been a fall in the cost of acyclovir, it is still quite costly and this has to be kept in mind while prescribing it in poor patients and others who can not get their medical bills reimbursed.

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