and temporary. Routine urine and haematological investigations were within normal limits. ASO titre was negative and pus swab from lesions did not grow any pathogen. Histopathology confirmed the diagnosis of subcorneal pustular dermatosis and significant regression of lesions was evident after dapsone therapy.

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FOCAL DERMAL HYPOPLASIA (GOLTZ SYNDROME)

To the Editor,

Focal dermal hypoplasia, also known as Goltz syndrome is characterized by widespread dysplasia affecting the tissues derived from embryonic ectoderm and mesoderm, with a striking underdevelopment of the dermis.[1] A 12-year-old girl was seen with hypopigmented and hyperpigmented macules and scars arranged in linear and retiform patterns bilaterally on the trunk (Fig.1). At birth she had a few linear raw areas on the skin of chest that healed in 6 months leaving atrophic, depigmented scars. Other anomalies noted were: a linear hyperpigmented, depressed atrophic area on the forehead, notching of the alae nasi on the left side, and macrochelia of lower lip (Fig.2). There were multiple, soft, compressible swellings on the chest that resulted from herniation of fat through the underdeveloped skin. Other congenital anomalies seen in her included complete

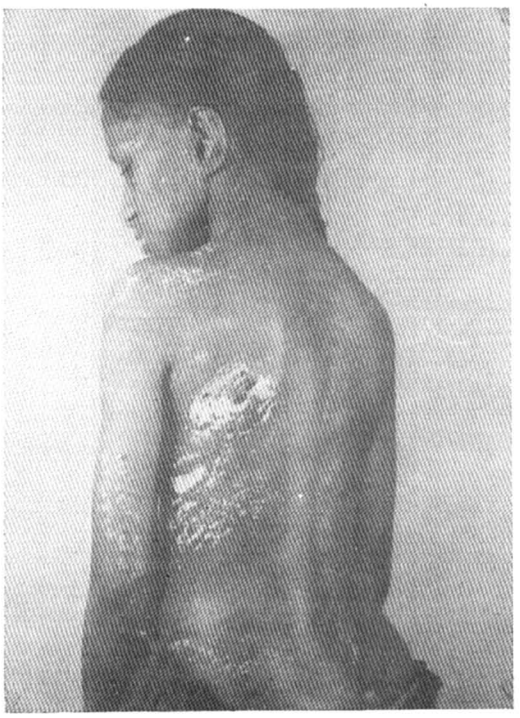

Fig 1. Goltz syndrome. Note linear,depigmented and hyperpigmented macules on trunk.

syndactyly of the left middle and ring fingers, microphthalmia with coloboma of the iris on the left eye, lumbo-sacral lordosis and a high-arched palate.

Routine laboratory tests on blood, urine and stools were normal. X-ray of the spine revealed spina bifida occulta of thoracic vertebrae (T_1 and T_2). Histology of the atrophic leasion on the chest revealed marked reduction in thickness of the dermis, the adipose tissue extending almost to the level of the papillary dermis. All the clinical features suggested a diagnosis of Goltz syndrome in this patient. Macrochelia and high arched palate were the additional features seen in our patient. The skin lesions in Goltz syndrome follow the course of Blaschko's lines, consistant with mosaicism secondary to lyonization of the affected X-chromosomes.[2]

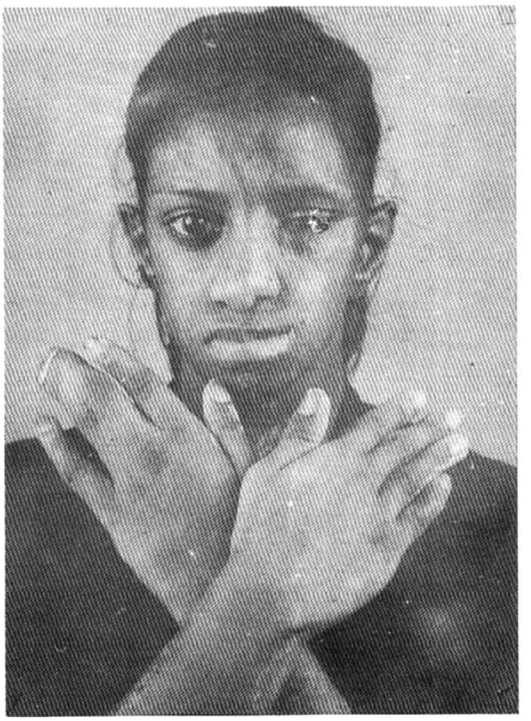

Fig 2. Note syndactyle, notched ala nasi and micro-phthalmia on the left side and macrochelia lower lip. There is a linear depressed scar on forehead.

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TINEA CAPITIS IN A 50-YEAR-OLD OWMAN

To the Editor,

A 50-year-old lady from Bhilai presented with itchy scalp lesions with hairloss for last one month. None of her family members had similar problem. She had attained menopause 5 years agao. There were no pets in her house. Scalp examination revealed an ill-defined, mildly scaly lesion with broken off hairs over the vertex, having irregular margins. The scales were dry, whitish and adherent. There were no other skin lesions, nail or systemic abnormality. KOH examination showed multiple chains of rectangular spores inside the hair shaft. Culture on Sabouraud's agar grew Trichophyton tonsurans. The lesion cleared completely after oral griseofulvin therapy for 5 months.

There are scanty reports of tinea capitis occurring in elderly patients.[1-5] Sebum secretion and colonization of scalp by Pityrosporum orbiculare help to protect the scalp against dermatophytic invasion. When tinea capitis occurs in adults, it is more frequent in post menopausal women.[1]

Different fungi viz. Trichophyton tonsurans, T. violaceum, T verrucosum, Microsporon canis, M. gypseum have been isolated in adult tinea capitis.[1] Rarely, T. rubrum has also been found responsible.[5] Unless the possibility of tinea capitis in elderly patients is entertained, there are chances of it being misdiagnosed.

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