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C O N T E N T S

EDITORIAL

Management of autoimmune urticaria

Arun C. Inamadar, Aparna Palit 89

VIEW POINT

Cosmetic dermatology versus cosmetology: A misnomer in need of urgent correction

Shyam B. Verma, Zoe D. Draelos 92

REVIEW ARTICLE

Psoriasiform dermatoses

Virendra N. Sehgal, Sunil Dogra, Govind Srivastava, Ashok K. Aggarwal 94



ORIGINAL ARTICLES

A study of allergen-specific IgE antibodies in Indian patients of atopic dermatitis

V. K. Somani 100

Chronic idiopathic urticaria: Comparison of clinical features with positive autologous serum skin test

George Mamatha, C. Balachandran, Prabhu Smitha 105



Autologous serum therapy in chronic urticaria: Old wine in a new bottle

A. K. Bajaj, Abir Saraswat, Amitabh Upadhyay, Rajetha Damisetty, Sandipan Dhar 109

Use of patch testing for identifying allergen causing chronic urticaria

Ashimav Deb Sharma 114

Vitiligoid lichen sclerosis: A reappraisal

Venkat Ratnam Attali, Sasi Kiran Attali 118



BRIEF REPORTS

Activated charcoal and baking soda to reduce odor associated with extensive blistering disorders

Arun Chakravarthi, C. R. Srinivas, Anil C. Mathew 122



Nevus of Ota: A series of 15 cases

Shanmuga Sekar, Maria Kuruvila, Harsha S. Pai 125



Premature ovarian failure due to cyclophosphamide: A report of four cases in dermatology practice

Vikrant A. Saoji 128

CASE REPORTS

Hand, foot and mouth disease in Nagpur

Vikrant A. Saoji 133



Non-familial multiple keratoacanthomas in a 70 year-old long-term non-progressor HIV-seropositive man

Hemanta Kumar Kar, Sunil T. Sabhnani, R. K. Gautam, P. K. Sharma, Kalpana Solanki, Meenakshi Bhardwaj 136



Late onset isotretinoin resistant acne conglobata in a patient with acromegaly

Kapil Jain, V. K. Jain, Kamal Aggarwal, Anu Bansal 139



Familial dyskeratotic comedones

M. Sendhil Kumaran, Divya Appachu, Elizabeth Jayaseelan 142



Nasal NK/T cell lymphoma presenting as a lethal midline granuloma

Vandana Mehta, C. Balachandran, Sudha Bhat, V. Geetha, Donald Fernandes



145

Childhood sclerodermatomyositis with generalized morphea

Girishkumar R. Ambade, Rachita S. Dhurat, Nitin Lade, Hemangi R. Jerajani.....



148

Subcutaneous panniculitis-like T-cell cutaneous lymphoma

Avninder Singh, Joginder Kumar, Sujala Kapur, V. Ramesh.....



151

LETTERS TO EDITOR

Using a submersible pump to clean large areas of the body with antiseptics

C. R. Srinivas



154

Peutz-Jeghers syndrome with prominent palmoplantar pigmentation

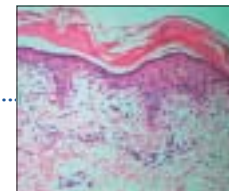
K. N. Shivaswamy, A. L. Shyamprasad, T. K. Sumathi, C. Ranganathan



154

Stratum corneum findings as clues to histological diagnosis of pityriasis lichenoides chronica

Rajiv Joshi



156

Author's reply

S. Pradeep Nair

157

Omalizumab in severe chronic urticaria

K. V. Godse.....

157

Hypothesis: The potential utility of topical eflornithine against cutaneous leishmaniasis

M. R. Namazi

158

Nodular melanoma in a skin graft site scar

A. Gnaneshwar Rao, Kamal K. Jhamnani, Chandana Konda



159

Palatal involvement in lepromatous leprosy

A. Gnaneshwar Rao, Chandana Konda, Kamal Jhamnani..... 161



Unilateral nevoid telangiectasia with no estrogen and progesterone receptors in a pediatric patient

F. Sule Afsar, Ragip Ortac, Gulden Diniz 163



Eruptive lichen planus in a child with celiac disease

Dipankar De, Amrinder J. Kanwar..... 164



Xerosis and pityriasis alba-like changes associated with zonisamide

Feroze Kaliyadan, Jayasree Manoj, S. Venkitakrishnan..... 165

Treatment of actinomycetoma with combination of rifampicin and co-trimoxazole

Rajiv Joshi 166



Author's reply

M. Ramam, Radhakrishna Bhat, Taru Garg, Vinod K. Sharma, R. Ray, M. K. Singh, U. Banerjee, C. Rajendran 168

Vitiligo, psoriasis and imiquimod: Fitting all into the same pathway

Bell Raj Eapen 169

Author's reply

Engin Şenel, Deniz Seçkin 169

Multiple dermatofibromas on face treated with carbon dioxide laser: The importance of laser parameters

Kabir Sardana, Vijay K. Garg 170

Author's reply

D. S. Krupa Shankar, A. Kushalappa, K. S. Uma, Anjay A. Pai..... 170

Alopecia areata progressing to totalis/universalis in non-insulin dependent diabetes mellitus (type II): Failure of dexamethasone-cyclophosphamide pulse therapy

Virendra N. Sehgal, Sambit N. Bhattacharya, Sonal Sharma, Govind Srivastava, Ashok K. Aggarwal 171



Subungual exostosis

Kamal Aggarwal, Sanjeev Gupta, Vijay Kumar Jain, Amit Mital, Sunita Gupta..... 173

Clinicohistopathological correlation of leprosy

Amrish N. Pandya, Hemali J. Tailor 174

RESIDENT'S PAGE

Dermatographism

Dipti Bhute, Bhavana Doshi, Sushil Pande, Sunanda Mahajan, Vidya Kharkar 177

FOCUS

Mycophenolate mofetil

Amar Surjushe, D. G. Saple 180

QUIZ

Multiple papules on the vulva

G. Raghu Rama Rao, R. Radha Rani, A. Amareswar, P. V. Krishnam
Raju, P. Raja Kumari, Y. Hari Kishan Kumar 185



E-IDVL

Net Study

Oral isotretinoin is as effective as a combination of oral isotretinoin and topical anti-acne agents in nodulocystic acne

Rajeev Dhir, Neetu P. Gehi, Reetu Agarwal, Yuvraj E. More 187

Net Case

Cutaneous diphtheria masquerading as a sexually transmitted disease

T. P. Vetrichevvel, Gajanan A. Pise, Kishan Kumar Agrawal,
Devinder Mohan Thappa 187



Net Letters

Patch test in Behcet's disease

Ülker Gül, Müzeyyen Gönül, Seray Külcü Çakmak, Arzu Kılıç 187

Cerebriform elephantiasis of the vulva following tuberculous lymphadenitis

Surajit Nayak, Basanti Acharjya, Basanti Devi, Satyadarshi Pattnaik,
Manoj Kumar Patra 188



Net Quiz

Vesicles on the tongue

Saurabh Agarwal, Krishna Gopal, Binay Kumar 188



complained of mild pain in the distal part of the left big toe while walking.

The nodular growth was well-defined in outline, firm in consistency, slightly tender and with a hyperkeratotic, smooth surface [Figure 1]. It projected out beyond the free edge of the medial border of the left hallucal nail, causing elevation of the nail plate. A presumptive diagnosis of subungual wart was made, but repeated attempts at superficial paring of the topmost layer of the hyperkeratotic subungual area did not cause any improvement in the lesion. Radiographs of the foot [Figure 2], taken at oblique angles and magnified, revealed an outgrowth of trabeculated bone projecting from the distal phalanx of the left big toe, on the dorsal aspect, with well-defined margins. There was no evidence of calcification of the soft tissues. No destructive changes were noted in the distal phalanx to suggest the possibility of a malignant lesion. This was interpreted as being consistent with the diagnosis of subungual exostosis.



Figure 1: Subungual nodule of left hallux



Figure 2: Roentgenograph showing subungual exostosis of left hallux

Subungual exostosis

Sir,

A 27-year-old female presented with a slowly enlarging, slightly tender nodular growth under the medial border of the left hallucal nail. The duration of the lesion was roughly 3 years. Prior to that time, her big toes were normal in appearance. The patient did not recall any major or minor trauma affecting this nail. There was no history of chronic infection of the left big toe. The patient

The patient underwent excision of the exostosis with satisfactory relief of symptoms. Histopathological study of the lesion was found to be consistent with the diagnosis of subungual exostosis. There has been no local recurrence after the patient underwent excision of the growth.

Subungual exostosis may be defined as a solitary, benign tumor of bone occurring on the distal phalanx beneath the nail.^[1] First described by Dupuytren in 1847,^[2] it has not been much remarked on in the recent years. This peculiar tumor is relatively uncommon.^[3] A solitary lesion most often occurs on the large toe^[1] but also has occurred on the lesser toes and even on fingers.^[4] A striking finding is the predilection for exostosis to occur on the inner border of the terminal phalanx of the large toe. Subungual exostosis usually develops during adolescence and is more common in females than males.

The cause of subungual exostosis is unknown. Many factors have been suggested, including trauma, chronic infection, tumor, hereditary abnormality or activation of a cartilaginous cyst.^[6]

Initially, in typical cases, a small firm lesion appears, which is usually located deep to the free edge of the nail. Pain, particularly severe on walking, develops due to the collision of the nail plate with the expanding exostosis. The overlying nail is pushed up and is finally detached, leaving a mass of fibrous tissue whose surface may become eroded and infected. This mass overlies the exostosis. Differential diagnosis at this stage may include the following: subungual verruca, granuloma pyogenicum, glomus tumor, carcinoma of the nail bed, melanotic whitlow, keratoacanthoma, subungual epidermoid inclusions and enchondroma, Köenen's tumor, keratoacanthoma and ingrowing toe nail.^[7]

Since enchondroma, like an exostosis, may involve the distal portion of a phalanx and cause nail changes, it deserves a special mention. Roentgenographically, an exostosis is seen as a bony outgrowth from the phalangeal bone while radiolucent enchondroma causes expansion of the phalanx itself. Excision and curettage of the subungual exostosis is the treatment of choice.^[7]

The purpose of this article is to highlight the fact that, while examining subungual lesions, the possibility of subungual exostosis should be considered as it is often missed because X-ray films are routinely not advised for such type of lesions.

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