from chronic plaque type psoriasis. In the latter there are usually some areas of uninvoloved skin. Psoriatic erythroderma may be the response to treatments like anthralin and UVB.[1] Itching is not an uncommon symptom among psoriatics. A 70-year-old man having psoriasis for past 36 years came for the treatment to relieve itching. He had chronic plaque type of lesions and suffered from many attacks of erythroderma in the past. He was prescribed terfenadine 60 mg bid. Within 6 hours of taking the first dose he experienced severe burning sensation all over the body and scales over the large plaques began peeling off. The exfoliation was complete within 24 hours of taking the first dose. The patient came the next day with generalised erythroderma without any univolved skin. He improved within 10 days of stopping the drug. A sudden onset of exfoliation of this kind was never seen there in him previously. Eight months later a rechallenge was done by an accidental consumption of terfenadine. This also resulted in total erythroderma by 24 hours in the same manner as on first occasion. Complete evaluation of the patient on both occasions ruled out other precipitating causes of erythroderma in psoriasis.

There is one report of terfenadine precipitating erythroderma in psoriasis.[2] Sudden in onset, almost instant precipitation of erythroderma in this patient indicated terfenadine as the precipitating cause. This has been proved by an accidental rechallenge of the durg.

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PKDL MIMICKING POST-INFLAMMATORY CHANGES OF PITYRIASIS ROSEA

To the Editor,

A 12-year-old boy presented to us with numerous well-defined hypopigmented macules over the lower part of the face, neck, trunk and proximal parts of limbs (Fig. 1)

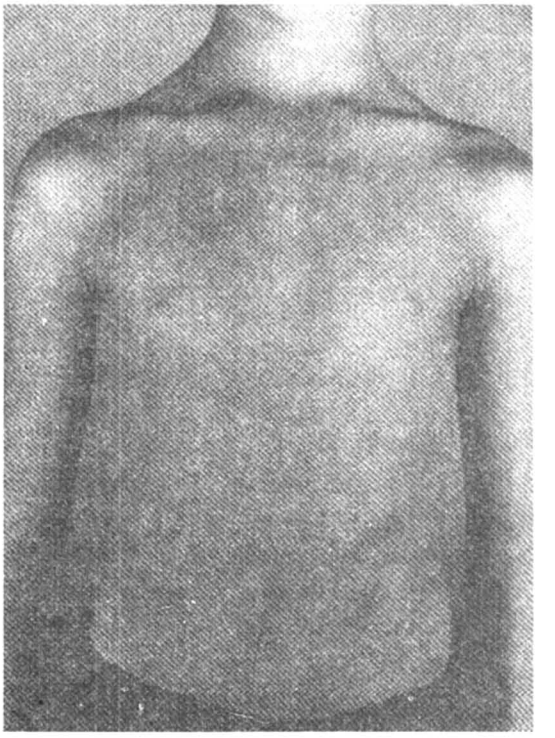

Fig. 1. Hypopigmented macules on the trunk and proximal parts of upper limb.

present for the last 6 months. Some had coalesced to form large patches but most of the lesions on the back were aligned along the long axes of ribs in a stricking "christmas tree" pattern (Fig. 2). The lesions were asymptomatic and slowly progressive while the sensations were intact. There were no features

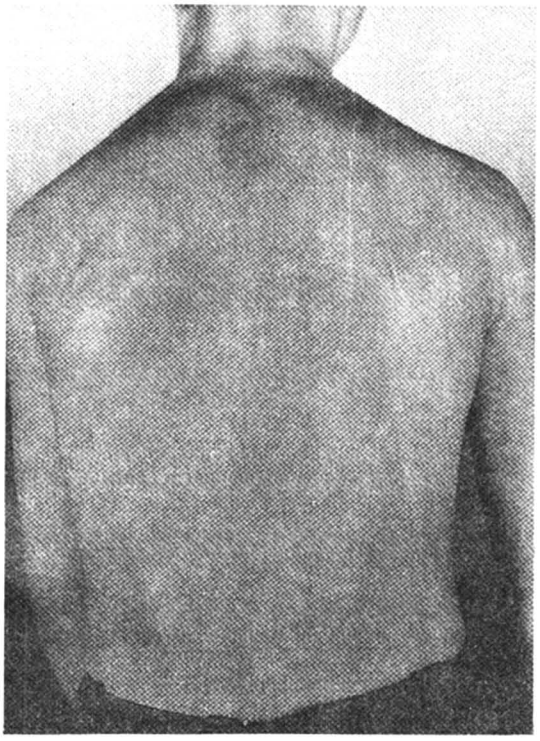

Fig. 2. Hypopigmented macules on the back resembling "christmas tree" pattern.

of nerve involvement. A diagnosis of pityriasis rosea was made at this juncture.

However, there was history of a prolonged continuous fever for 5 months with swelling in the left side of abdomen about 4 years before the onset of skin lesions. This was successfully treated with about 20 intramuscular injections of pentavalent antimony after being diagnosed as kala-azar. The patient belonged to Ramnagar (UP) which is an endemic area for kala-azar.

The histopathological examination of the biopsy specimen taken from a lesion showed in the upper dermis an infiltrate of lymphocytes, plasma cells and histiocytes. The slit-skin smear examination was inconsequential. The diagnosis was changed to post-kala-azar dermal leishmaniasis (PKDL). This case is being reported because of its peculiar resemblance to the post-inflammatory changes of pityriasis rosea.

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FIXED DURATION MDT IN LEPROSY

To the Editor,

This letter is in reference to the article by Paramjit Kaur and Gurmohan Singh on 'Fixed duration MDT in leprosy and clinical cure' (IJDVL 1996;62:33-5).

We think practically all will agree that it is advisable to achieve clinical cure. We however do not agree that the patients covered by the national programme should have different treatment than patients under care of dermatologists. This is especially so because of the ever increasing incidence of relapses after FDT.[1]

We are giving herewith the opinion of practising dermatologists from all over Maharashtra (except Mumbai) who were asked questions related to FDT. Out of the 142 dermatologists contacted 92 responded.

1. For monolesional paucibacillary cases 88.1% do not stop treatment at the end of 6 months as suggested by WHO.

2. For paucibacillary cases with multiple lesions 81.5% do not stop treatment at the end of 12 months as suggested by WHO.

3. For multibacillary cases 93.5% do not stop treatment at the end of 24 months.

Thus overwhelming number of dermatologists give importance to the clinical activity and do not follow the FDT schedules as suggested by WHO.

We would like to add from our experience that with relative affluence in our state, not so costly MDT and availability of qualified dermatologists in all district places