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We hope that making available the relevant information on Pachyonychia Congenita will be a means of furthering research to find effective therapies and a cure for PC.
CORRESPONDENCE.

The Editor, 'The British Journal of Dermatology'.

Pachyonychia congenita—favourable response to sodium laevothyroxine.

SIR,—Pachyonychia congenita, a rare congenital and often familial disease is characterized by thick black stony hard nails, follicular keratotic lesions scattered over the body with verrucous lesions on knuckles, knees, elbows, popliteal spaces, back and neck of blistering on the soles and face and oral leukokeratosis. There is no radical treatment of pachyonychia congenita except surgical amputation of phalanges (Wright and Jacques, 1947). Curettage of phalanges and soft tissue removal (Andrews, 1935, 1936; Cosman et al., 1964) result in failure as nails regrow from the nail matrix. Vitamin A in heavy doses for follicular keratotic lesions and cystein hydrochloride for blisters of the soles have been advocated (Wright and Jacques, 1947).

We report here such a case for the first time from India in a boy of 00 with a moderate degree of mental retardation. Investigations: B.M.R. —10, serum cholesterol 177 mg.%, P.B.I. normal, blood chemistry and liver function tests normal, routine blood, stool and urine examination normal. Histology of keratotic lesion confirmatory to the diagnosis.

The patient was given sodium laevothyroxine 0.2 mg. daily for five weeks, by which time all the follicular lesions had improved, the skin became smooth and soft and the hair coarse. After increasing the dose to 0.4 mg. daily for further three weeks, all the diseased nails became loose and fell off leaving uneven pink nail at the proximal part of the nail bed. As the patient was losing weight, the dose was reduced to 0.2 mg. daily and vitamin A 50,000 units daily was supplemented for three months. The nails regrew to their original pattern but were much less thick. The improved condition of the skin and hairs was maintained. The periodic appearance of blisters on the soles was minimized and none appeared on the face. The patient has continued taking 0.1–0.2 mg. of the drug once or twice a week irregularly. The overall improvement is being maintained.

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REFERENCES.


The Editor, 'The British Journal of Dermatology'.

Seborrhoeic dermatitis with moniliasis.

SIR,—Warin and Faulkner have certainly stimulated much discussion and writing by their original description of an entity, designated napkin psoriasis. Warin's recent review encourages further letters and at the risk of appearing controversial I wish to state that it appears unjustified to describe this condition as psoriasis.

There is no doubt that lesions clinically suggestive of psoriasis are seen, but the syndrome is complex. Auckland suggests that the condition is purely psoriasis and favours the title of infantile psoriasis. All other publications acknowledge the possible roles of seborrhoeic eczema and moniliasis. Ferguson et al., in a review of