The interesting point about this case was that the activity of DH was closely associated with the inflammatory state of chronic tonsillitis. Several lines of evidence support this conclusion: First, the eruption was clinically reproducible by surgical manipulation of the tonsils. Secondly, lymphocytes harbouring in the patient's tonsil expressed predominantly IgA. This finding is noticeable because the majority of lymphocytes in normal tonsils express IgG in much the same way as chronic tonsillitis without complications (9, 10). Under certain conditions, such as IgA nephropathy, which is possibly induced by tonsillitis, IgA expressing lymphocytes are predominant (10, 11). Thirdly, granular IgA deposits in the dermal papillae disappeared after tonsillectomy.

The current explanation for DH is that lymphocytes recruited in conjunction with GSE produce IgA autoantibodies that also react with dermo-epidermal junction (12). In the present case, the inflammatory reaction in the tonsils might be responsible for producing IgA class autoantibodies that react with the dermo-epidermal junction.

REFERENCES

1. Katz SI, Hall RP III, Lawley TJ, Strober W. Dermatitis herpetiformis: the skin and the gut. Ann Intern Med 1980; 93: 857–874.
2. Arnason A, Skaftadottir I, Sigmundsson J, Mooney E, Bjornsson J, Cariglia N, et al. The association between coeliac disease, dermatitis herpetiformis and certain HLA-antigens in Icelanders. Eur J Immunogenet 1994; 21: 457–460.
3. Leonard J, Haffenden G, Tucker W, Unsworth J, Swain F, McMinn R, et al. Gluten challenge in dermatitis herpetiformis. N Engl J Med 1983; 308: 816–819.
4. Shimizu K, Hashimoto T, Fukuda T, Watanabe K, Ishiko A, Nizeki H, et al. A Japanese case of the fibrillar type of dermatitis herpetiformis. Dermatology 1995; 191: 88–92.
5. Kasahara M, Hosokawa H, Hayami M, Asada Y. Dermatitis herpetiformis with granular or fibrillar IgA depositions. Rinsho Derma (Tokyo) 1995; 37: 601–605 (in Japanese).
6. Hattori N, Okochi H, Kikuchi K, Furue M. Dermatitis herpetiformis Duhring. Rinsho Derma (Tokyo) 1998; 40: 263–266 (in Japanese).
7. Hashimoto K, Miki Y, Nishioka K, Nakata S, Matsuyama M. HLA antigens in dermatitis herpetiformis among Japanese. J Dermatol 1980; 7: 289–291.
8. Fry L, Seah PP, Harper PG, Hoffbrand AV, Mcminn RMH. The small intestine in dermatitis herpetiformis. J Clin Path 1974; 27: 817–824.
9. Hata M, Asakura K, Saito H, Morimoro K, Kataura A. Profile of immunoglobulin production in adenoid and tonsil lymphocytes. Acta Otolaryngol (Stockh) 1996; Suppl 523: 84–86.
10. Bene MC, Faure G, Hurault de Ligny B, Kessler M, Duheille J. Immunoglobulin A nephropathy. Quantitative immunohistomorphometry of the tonsillar plasma cells evidences an inversion of the immunoglobulin A versus immunoglobulin G secreting cell balance. J Clin Invest 1983; 71: 1342–1347.
11. Egido J, Blasco R, Lozano L, Sancho J, Garcia-Hoyo R. Immunological abnormalities in the tonsils of patients with IgA nephropathy: inversion in the ratio of IgA: IgG bearing lymphocytes and increased polymeric IgA synthesis. Clin Exp Immunol 1984; 57: 101–106.
12. Hall RP. The pathogenesis of dermatitis herpetiformis: recent advances. J Am Acad Dermatol 1987; 16: 1129–1144.

Multiple Becker's Naevi: A Rare Presentation

Binod K. Khaitan[1], Yashpal Manchanda[1], Rashmi Mittal[1] and Manoj K. Singh[2]
Departments of [1]Dermatology & Venereology and [2]Pathology, All India Institute of Medical Sciences, New Delhi, 110029, India.
E-mail: binodkhaitan@hotmail.com

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Sir,

Becker's naevus (pigmented hairy epidermal naevus), a variety of epidermal naevus (1) is present in about 0.5% of young men (2). It is about 5 times more frequent in males than in females. Characteristically, it is a unilateral single lesion of the shoulder, upper arm, anterior chest or scapular region in males, appearing during adolescence. It may affect other sites, e.g. the lower limb (3, 4). It may rarely also be multiple and bilateral (5). We report here a rare case of multiple Becker's naevi with 7 distinct lesions present on different sites including the lower limbs.

CASE REPORT

A 28-year-old male consulted us for multiple, asymptomatic light to dark-brown macules that had been present for 15 years over both lower extremities, abdomen and front of chest, extending on to the left upper limb. At first, the patient noticed multiple asymptomatic light-brown macules over the left lower limb, which coalesced to form a larger patch and the pigmentation also grew darker. He noticed increased hair growth over the lesion and gradually over the years he developed 6 similar lesions on the chest, abdomen and right lower limb. There was no history to suggest any neurological or any other systemic illness.

On cutaneous examination, 7 light-brown to dark-brown macules of sizes varying from 10×15 cm to much larger areas covering almost half of the lower limb with a "splash on" appearance at the periphery and central hypertrichosis in most of them. The lesions were situated on the chest, abdomen, back and right groin, extending on to the medial aspect of the right thigh, both knees and anterior aspect of both legs, left arm and forearm (Fig. 1). The lesions on the chest and anterior abdominal wall showed a sharp midline margin. Thorough physical examination did not reveal any neurological or musculoskeletal defect. Routine laboratory investigations including a haemogram, liver and renal function tests, urinalysis and examination of stool were all within normal limits. X-ray of the chest, spine and lower extremities did not reveal any pathological findings. Histopathological examination of the lesion from the chest showed mild acanthosis with increased pigment (melanin) in the basal cell layer, especially at the

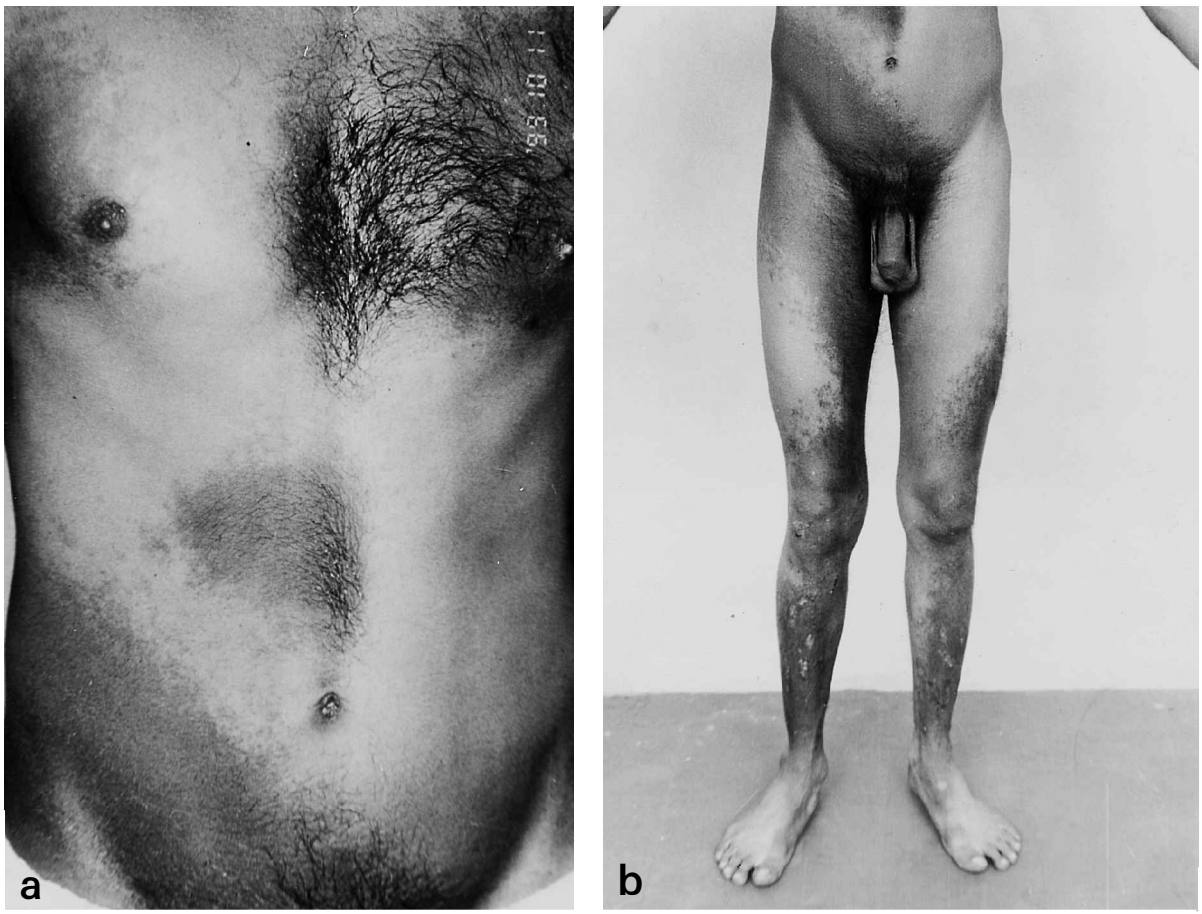

Fig. 1. Lesions on the trunk (*a*) and on the lower extremities (*b*).

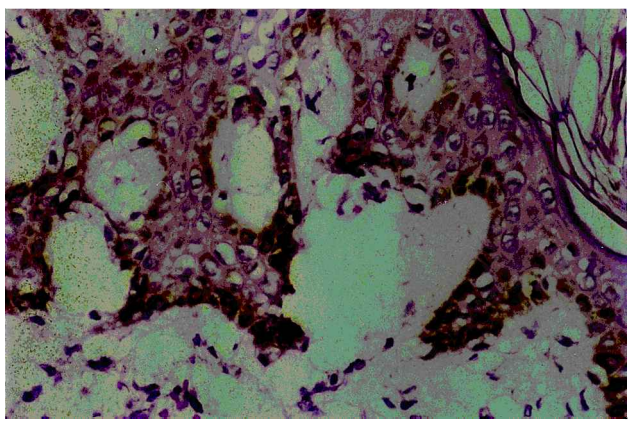

Fig. 2. Histopathology of the lesion.

bases of the rete ridges (Fig. 2). Smooth muscle bundles were seen, though these were considered within normal limits.

DISCUSSION

Becker's naevus has classically been described as acquired, localized, unilateral hypermelanosis around the shoulders of adolescent males, but since the original description of the entity, the definition has undergone numerous changes. An extensive search of the literature has revealed fewer than 10 patients described with multiple lesions. Our patient had 7 distinct lesions, which we believe is an unusually high number and perhaps the highest reported so far. The sharp midline cut-off in the truncal lesions, as in other cases, has been suggested to be due to the development of the lesion at the time of organogenesis but manifesting later in life.

REFERENCES

1. Becker SW. Concurrent melanosis and hypertrichosis in the distribution of naevus unius lateris. Arch Dermatol Syphil 1949; 60: 155–160.
2. Frainbell W, Rook A. Pigmented and hypertrichotic epidermal naevus. Trans St John's Hosp Derm Soc NS 1957; 39: 51.
3. Tymen R, Forestier JF, Boutet B, Colomb B. Nevus tardif de Becker. Ann Dermatol Venereol 1981; 108: 41–46.
4. Khaitan BK, Dogra D, Manchanda Y, Rathi S. Becker's naevus of the lower limb. Acta Derm Venereol 1998; 78: 238–239.
5. Copeman PWM, Wilson Jones EWJ. Pigmented hairy epidermal naevus (Becker). Arch Dermatol 1965; 92: 249–251.