3. Melhorn DK, Gross S, Newman AJ. Acute childhood leukemia presenting as aplastic anemia: the response to corticosteroids. J Pediatr 1970, 77: 647-653.
4. Breatnach F, Chessels JM, Greaves MF. The aplastic presentation of childhood leukemia: A feature of common ALL. Br J Hematol 1981, 49: 387-393.
5. Choudhry VP, Arya LS. Evaluation of different induction regimens in children with acute lymphocytic leukemia. Indian J Pediatr 1988, 55: 789-795.
6. Pierre RV. Preleukemic states. Semin Hematol 1974, 11: 73-91.
7. Choudhry VP, Adhikari RK, Saraya AK. Aplastic anemia-An early phase preceding acute lymphatic leukemia. Indian J Pediatr 1982, 49: 343-347.
8. De Vaan GAM, Van Oostrom CG. The aplastic presentation of childhood leukemia. Br J Hematol 1982, 50: 712-713.
9. Poplack DG, Kun LE, Cassady JR, Pizzo PA. Leukemias and lymphomas of childhood. *In:* Cancer: Principles and Practice of Oncology. 3rd edn. Eds De Vita VT, Hellman S, Rosenberg SA. Philadelphia, JB Lippincott Co., 1989, p 1675.

Tuberculides: An Uncommon Manifestation of Tuberculosis

G. Gathwala
P.C. Gupta
S. Aneja

Tuberculosis is a common disease of childhood in India. However, skin tuberculides though common once are rather rare now(1). We report a child of miliary tuberculosis with skin tuberculides.

Case Report

A 1½-year-old male child was brought to the hospital with the presenting complaints of low grade intermittent fever and cough for 1½ months. In the preceding one month the child had developed raised reddish-purplish spots on the entire body. These came in crops appearing first on the lower trunk and then spread to involve the whole body especially the extensor aspects of the extremities. There was no itching. There was history of decreased oral intake and loss of weight. The child was unimmunised. The father was a known case of tuberculosis taking irregular treatment from a local doctor.

On examination, the general condition of the child was unsatisfactory. He was irritable with a pulse rate of 108/min, a respiratory rate of 40/min and a temperature of 100°F. He was pale and had significant cervical and axillary lymphadenopathy. There was a reddish-purplish papular rash that was symmetrically distributed but more marked on the extensor surfaces (*Fig. 1*). The abdominal examination revealed hepatomegaly of 6 cm and a splenomegaly of 4 cm. The rest of the systemic examination was essentially normal.

Investigations revealed a hemoglobin of 7.5 g/dl, TLC of 10,000/cu mm. DLC $P_{50}L_{46}M_2E_2$, ESR 64 mm and peripheral smear showed microcytic hypochromic anemia. Mantoux test was 15 mm at 72 hours with 5 TU. *X*-ray chest showed soft

From the Department of Pediatrics, Kalawati Saran Children's Hospital and Lady Hardinge Medical College, New Delhi 110 001.

Reprint requests: Dr. Geeta Gathwala, H. No. 811, Opposite NFL Area Office, Jhang Colony, Rohtak 124 001.

Received for publication September 26, 1990; Accepted February 5, 1991

Fig. Tuberculides: Reddish-purplish papular lesions that are symmetrically distributed but more marked on the extensor surfaces.

miliary opacities in both lung fields with a right paratracheal lymphnode. Gastric aspirate for acid fast bacilli was negative.

The histological examination of skin biopsy revealed tubercle formation with many giant cells. Special staining by the Ziehl Neelsen technique, demonstrated acid fast bacilli which were sparsely distributed. Liver function tests, cerebrospinal fluid examination, blood urea and serum electrolytes were within normal limits.

A diagnosis of miliary tuberculosis with skin tuberculides was made and the child was put on antitubercular treatment (streptomycin, isonex and rifampicin). The skin lesions disappeared rapidly over the next few days and the child improved.

Discussion

Skin tuberculides occur preferentially in children and young adults(1). A deep focus of tuberculosis is present in more than one third of cases and a prompt response to antitubercular therapy is generally seen(2,3). Morrison and Fourie(2) believe that from a tuberculous focus, bacilli periodically enter the circulation where they are opsonised with antibodies and complement and settle out preferentially in slow flowing capillaries in the skin. They suggest that the tuberculide represents an arthus reaction followed by a delayed hypersensitivity response to mycobacteria.

REFERENCES

1. Wolff K, Tappeiner G. Mycobacterial diseases: Tuberculosis and atypical mycobacterial infections. *In:* Dermatology in General Medicine, 3rd edn. Eds Fitzpatrick TB, Eisen AZ, Wolff K, Freedberg IM, Austen KF. New York, McGraw Hill Book Company, 1987, pp 2166-2167.
2. Morrison JGL, Fourie ED. The papulonecrotic tuberculide–From Arthus reaction to lupus vulgaris. Brit J Dermatol 1974,91: 263-270.
3. Miller FJW. Tuberculosis in children, 1st edn. Edinburgh, Chruchill Livingstone, 1982, pp 149-150.

Prolonged Traumatic Transient Cortical Blindness Following Head Injury

U.K. Singh

Cortical blindness occurs in children after head injury. In typical cases, blindness

From the Department of Pediatrics, Patna Medical College Hospital, Patna.

Reprint requests: Dr. Utpal Kant Singh, Rajendra Nagar, Road No. 8, Patna 800 016.

Received for publication March 16, 1990; Accepted February 11, 1991