in this disorder was not present in our patient. Serum cholesterol and uric acid levels were normal.

Our patient also had steroid-induced striae and atrophy of the skin. However, this was unrelated to the characteristic presentation of MSL, where the lipomatous growths were confined to the shoulders, upper part of trunk and the proximal extremities. There was conspicuous sparing of the face, involvement of which is universally seen in patients with Cushing’s syndrome. The association of chronic actinic dermatitis and MSL in our patient is probably inconsequential, like many other associations reported in the literature.

REFERENCES

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Neena Khanna MD, Devraj Dogra MD, Sanjay K Rathi MBBS and J. S. Ravindraprasad MBBS Department of Dermatology & Venereology, All India Institute of Medical Sciences, New Delhi, India.

Healing Rate of Skin Ulcers

Sir,

Interferometry for measuring the surface area and volume of ulcerous skin lesions, as described by Altmeyer et al. (1), may evolve into a useful tool in quantifying healing, such as before and after application of trophic factors. A working hypothesis is needed to place observations on healing rates into a conceptual framework. There are at least 2 problems: 1) healing may not be uniform over the full extent of the lesion, and 2) exquisite accuracy in repeat measurements may be required to distinguish between competing descriptions of the healing process. We illustrate these two points.

A first assumption is that since nutrients are delivered across the surface of the lesion, the rate of change of volume over time should be proportional to the surface area.

\[
d(\text{volume})/dt = \text{surface area} \ (1)
\]

Since many ulcerous lesions can be approximated as a depression corresponding to a hemisphere, we can utilize values for the volume of a hemisphere and its surface area. Substituting into equation (1) and integrating yields:

\[
R = kt \ (II)
\]

The prediction is that the radius changes linearly with time. This is consistent with the values shown below Fig. 5 in the report of Altmeyer et al. on the depth of the lesion and is shown in our Fig. 1.

![Fig. 1. The change in radius (depth) of an ulcerous lesion versus time, using values given below Fig. 5 of Altmeyer et al.](Acad Derm Venereol (Stockh) 76)

![Fig. 2. The change in volume of the ulcerous lesion versus time.](Acad Derm Venereol (Stockh) 76)
In Response to the Letter to the Editor by R. P. Spencer

In our paper the results of the evaluation of interferometry, a technique developed for engine building, are presented. With regard to ulcers of the lower leg and follow-up of healing of an ulcer, the accuracy and reproducibility of interferometry is demonstrated and compared to established standardized methods like planimetry and measurement of the volumes of ulcers using casts.

First of all, we would like to thank Dr. Spencer for his constructive and original contribution to the interpretation of parameters obtained by interferometry in wound healing. The description of wound healing processes by mathematical models is an interesting and promising approach.

However, as far as the examples in our publication are concerned, presently no formula can be derived expressing the correlation between the parameters measured using interferometry. Which of the three parameters volume, surface and depth is most suitable to quantify healing depends on the individual ulcer. We believe that simple geometrical models, like spheres, pose problems when describing wound healing processes as they neglect the biological individuality of lesions. Exact quantification of healing processes requires the measurement of volumes, surface and depth as well as area of the lesions using planimetry.

Interferometry is a valuable technique to quantify wound healing of ulcers without touching the surface. Effects of different therapeutic regimens on healing can be studied.

For the development of geometrical models for evaluation of wound healing the correlation of objective and reproducible measurement parameters with clinical data like etiology, location, healing stage and treatment is necessary in a great number of objects, e.g. using silicon casts of ulcers. This could be provided in a multicenter study under standardized conditions, comparing several therapeutic approaches by means of interferometry.

P. Altmeyer, H. Erbler, T. Krömer, H. P. Duwe and K. Hoffmann
Dermatologische Klinik, Gudrunstraße 56, D-44791, Bochum, Germany.

A Giant Solitary Molluscum Contagiosum, Resembling Nodular Basal Cell Carcinoma, in a Renal Transplant Recipient

Sir,

Molluscum contagiosum (MC) is a poxvirus infection characterized by single or more often multiple, rounded, dome-shaped, pink, waxy papules. These centrally umbilicated lesions, 2–5 mm in diameter, are usually localized on the face, arms, legs and anogenital regions. The diagnosis is easily established in most instances (1).

In HIV-infected patients and immunocompromised individuals, MC is a frequent problem (2). In this article, we present a case of giant solitary MC resembling nodular basal cell carcinoma in a renal transplant recipient.

CASE REPORT

A 24-year-old male renal transplant patient presented with a 2-month history of a tumoral lesion on his face. At the time of clinical examination, he had been using immunosuppressive drugs (cyclosporine: 100 mg/day, azathioprine: 100 mg/day and prednisolone: 7.5 mg/day) orally for 10 months.

Dermatologic examination revealed increased skin fragility, striae distensae, acneform eruptions, hypertrichosis, facies lúbris, and a telangiectatic, centrally umbilicated nodule, 8 x 10 mm in size, below the right lower eyelid (Fig. 1). An excisional biopsy specimen of this lesion showed an acanthotic epidermis with an intense epidermal proliferation, with giant craters full of numerous intracytoplasmic inclusion bodies, typical of MC.

DISCUSSION

Disseminated lesions of MC have been observed in immunocompromised hosts, especially in those infected with HIV. Most of these patients appear to have a deficiency in either the function or absolute numbers of T lymphocytes (2, 3).