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Letter to the Editor

Dear Editor,

We read with great interest the original article titled 'Spectrum of ocular diseases in patients attending eye camps in Andaman and Nicobar' by Singh et al. published in *Med J Armed Forces India* 2016; 72(1): 45–47.¹ Our compliments to the authors on publishing their work, which brings out the burden of ocular diseases in the remote islands of Andaman and Nicobar based on eye camps, the first of its kind. Remote locations are plagued with problems of communication, transport, and lack of local medical infrastructure, which pushes up the prevalence of various ailments, as seen in this study. Surveys conducted in the mainland also report a similar trend of higher prevalence in rural remote parts of the country as compared to urban India.^{2,3} Latest estimates put the nationwide prevalence of blindness in India at 1%, with cataract accounting for 60% of this blindness (0.6%).^{5,6} These surveys have taken vision less than 3/60 (WHO criteria) as the criteria for blindness. The prevalence of impaired vision (vision less than 6/18) is even higher.⁴ We would, however, like to point out that periodical camps in remote locations tend to attract selectively those with ocular ailments, and therefore will show higher percentages of various diseases than is actually prevalent. Therefore, we would caution against interpreting the prevalence rates reported by the authors in this article as truly representative of the actual prevalence in the reference population, for which a well-designed population survey is required. Nevertheless, it does give an estimate of the burden of ocular diseases in these remote locations, which could be useful in planning of eye care facilities for these areas and carrying out future population-based surveys. The increase in the prevalence of cataract with increase of distance from the main island is expected as difficulty in seeking care due to remoteness leads to accumulation of cases between camps. We would also like to know if the patients seen in their camps included people of aboriginal ethnicity apart from settlers from mainland and what was the distribution of ocular ailments in this subgroup.

Conflicts of interest

The authors have none to declare.

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Reply

Dear Editor,

We thank the authors for showing great interest in our original article titled 'Spectrum of ocular diseases in patients attending eye camps in Andaman and Nicobar' by Singh et al. published in *Med J Armed Forces India* 2016; 72(1): 45–47.¹ As the author has rightly pointed out that survey done by NPCB² has taken the cutoff of vision <3/60 for screening purpose for criteria of blindness. Some more studies such as conducted by Murthy et al.³ and Kanagarajan et al.⁴ have taken the visual acuity <6/60 as screening criteria to see the prevalence of cataract. To see the actual prevalence of different eye diseases in these islands, a large well design population survey is required. The study conducted near Portblair (Long and Neil island) has mixed ethnicity and in other far flung islands like Car Nicobar, Teressa, Chaura island, the proportion of local tribes like Nicobarese of Mongolian descent and Shompen tribes of great Nicobar with few of Sentinelese were seen. The exact percentage of different eye diseases in these tribes could not be determined as ethnicity factor was not included in this study.

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Letter to the Editor

Periodic acid Schiff's: A definitive stain in histopathological diagnosis of Cylindroma

Dear Editor,

Cylindroma, also called as 'Turban tumor', is a slow growing, benign adnexal tumor which is seen in head and neck region.¹ The tumor has a characteristic histology composed of basaloid cells arranged in a 'Jigsaw puzzle' pattern with presence of intervening basement membrane material which is positive on Periodic Acid Schiff's (PAS) stain.^{1,2} The PAS positive basement membrane material acts as a useful adjunct in differentiating the tumor from other possible diagnosis such as malignant melanoma, basal cell carcinoma, spiradenoma, and trichoepithelioma. We discuss 2 cases which were clinically suspected to be a probable malignant melanoma.

The first case was a 70-year-old female with a 2 cm × 1 cm pigmented raised skin lesion in the right retroauricular region and the other case was of a 60-year-old male with a 1.5 cm × 1 cm similar pigmented raised skin lesion over the scalp. Both individuals gave a short history of 4–6 months

duration. With a clinical suspicion of malignant melanoma, a wedge biopsy of the lesions was undertaken. Histopathological examination of the lesions shows an intact epidermis. The dermis showed a well-circumscribed lesion separated from the epidermis by a thin uninvolved zone. The first case showed the lesion to be composed of nests and tubules of basaloid cells. The nests of cells were seen to be arranged in a 'Jigsaw puzzle' pattern (Fig. 1A). No retraction artifact was seen. The cells were composed of peripheral palisaded cells with dark nuclei and central cells with paler nuclear chromatin and presence of intra-tumoral melanin (Fig. 1A). No nuclear pleomorphism or prominent nucleoli was seen. No mitosis or necrosis was seen. The second case shows similar basaloid cells in cords and tubules with peripheral palisading (Fig. 1B and C). However, the 'Jigsaw puzzle' pattern was absent. The PAS stain done in both cases clearly delineated the presence of PAS positive basement membrane material between the cords and around the tubules and cell nests confirming the diagnosis of Cylindroma (Fig. 1D).