T cells.[5] However, the exact mechanism of the bidirectional effect of thalidomide on TNF-α is not clear. Immune stimulation has been reported in scleroderma patients treated with thalidomide.[6] In a randomized study comparing thalidomide vs. placebo in toxic epidermal necrolysis[7] there was a paradoxical overproduction of TNF-α leading to excess mortality. There was a similar observation of increased plasma TNF-α and soluble TNF-α receptors with thalidomide treatment for oral aphthous ulcers in human immunodeficiency virus-1-infected patients.[8] Thalidomide, at a concentration achieved *in vivo*, could either enhance or suppress the synthesis of TNF-α *in vitro* depending on the type of cells stimulated.[9,10] This leads to the suggestion that, in certain circumstances, thalidomide could paradoxically enhance the production of TNF-α.

We hypothesize that the flare of our patient's psoriasis was due to a thalidomide-induced increase in TNF-α. We suggest cautious use of thalidomide in patients with coexisting psoriasis.

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The role of immunosuppression in the pathogenesis of basal cell carcinoma

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Sir, Tilli *et al.* in their comprehensive review of the molecular aetiology and pathogenesis of basal cell carcinoma (BCC) questioned the impact of a depressed immune system in the development of BCC.[1] They alluded to the lack of evidence to support an increase in BCC incidence rates following organ transplantation and stated that 'immunosuppression as practised after organ transplantation does not increase the risk of developing BCC'.

The paucity of reliable evidence in relation to post-transplant BCC is in part a reflection of the practice of most cancer registries, not to record BCCs, or instead to include both squamous cell carcinoma (SCC) and BCC under the collective heading of nonmelanoma skin cancer.[2,3] In addition, many registries will register only the first nonmelanoma skin cancer for an individual, a practice which would result in a significant underestimation of the skin cancer burden of a transplant population, where individuals often develop multiple skin cancers.[4]

The Irish National Cancer Registry has since 1994 registered all histologically confirmed skin cancers including BCC, SCC, malignant melanoma and preinvasive skin cancers for the largely homogeneous population of the Republic of Ireland. Provided that sites of the cancers were more than 5 cm apart and clearly not metastatic, each cancer, even of the same histological type, is counted.

In a cohort study of cancer patterns in Irish renal transplant recipients we have demonstrated a 16-fold excess risk of BCC relative to an age-matched nontransplanted population.[5] An examination of the incidence of BCC by each year of cumulative immunosuppression and age demonstrates that the risk increases as early as year 2 post-transplant for older renal transplant recipients, reaching a peak of 30 times the national incidence by year 5. In contrast, younger transplant recipients develop BCC later but with continued immunosuppression demonstrate a dramatically increased risk, 130 times the incidence seen in an age-matched nontransplanted population by year 12 post-transplant.

The reason why post-transplant immunosuppression promotes SCC development to a greater degree than BCC development remains under investigation. BCC does not demonstrate the direct correlation with cumulative ultraviolet (UV) dose seen with SCC; however, infrequent intense exposure to UV may have a greater influence on increasing risk of BCC than total cumulative UV exposure.[6,7] Interestingly, the reversal of SCC/BCC ratio is seen much more dramatically in Northern European and Australian transplant populations than in Mediterranean transplant populations.[8,9] This geographical variation is likely to result from different genetic backgrounds, skin types and sun exposure habits at different latitudes.

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Raised limb bands developing in infancy

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Sir, We previously reported two patients with raised limb bands that were not present at birth and developed during the first year of life.[1] Limb bands can be raised above the skin surface with no associated constriction or the skin thickening can lie within a constriction in the limb. Here we report another four patients who have since been under our care. All four children were born to nonconsanguineous parents. The bands were asymptomatic and not associated with any other limb abnormalities.

Patient 1 is a white female infant born at term following an uncomplicated pregnancy; she developed a linear lesion on the left calf at 7 months of age. She had asthma and atopic eczema. There was no family history of similar lesions. Examination at 7 months showed a skin-coloured, 3-mm thick, linear raised band of skin running obliquely on the posterior aspect of the leg. A few millimeters above this limb band there was a shorter, finer, less distinct band running nearly parallel to it. The bands were not causing any constriction in the leg. Follow-up at 25 months of age showed no change in appearance (Fig. 1).

Patient 2 is a 13-month-old Indian girl who was referred regarding a lesion on the right calf, which had appeared at 1 month of age. She was born at 36 weeks' gestation by elective caesarean section due to maternal pre-eclampsia and intrauterine growth retardation. At birth she weighed 2·13 kg and the postnatal period was uncomplicated. There was no family history of similar lesions. She had a raised, skin-coloured, 3-mm wide band of skin running horizontally across the mid-calf on the posterior aspect of the right leg, without any associated constriction. At 34 months of age the limb band remained unchanged.

Patient 3 is a white girl who was seen at age 2 and a half years regarding bands on both forearms which had developed at 6 months of age. She had symmetrical, 2-mm thick, raised bands associated with slight depression of the skin surface. The bands were partially circumferential around both mid-forearms. Four months previously, similar less distinct constrictions had been noted by the referring clinical geneticist, but these had resolved by the time the patient was seen by us. The patient's 14-month-old sister (patient 4) had similar bands that had developed at 1 month of age on both forearms. Both siblings had been born at term following uncomplicated pregnancies and were subsequently lost to follow-up.

The clinical features of these four patients and previously reported cases are summarized in Table 1. In 2003 Russi *et al.*[2] reported a 13-month-old boy with bilateral raised limb bands on the posterior lower legs, which were absent at birth and developed within the first 2 months of life. This patient bears much similarity to patients 1 and 2 herewith described. The two patients we originally reported[1] differed from the rest in that they were both severely preterm.

In three of our six cases the raised limb bands were associated with subtle limb constrictions: in all three these developed in infancy, although patient 1 in our previous report[1] also had a congenital constricting limb band and two shortened toes. The development of raised limb bands in a child with a congenital limb constriction and shortened toes suggests that raised limb bands developing in infancy may share a common aetiology with the amniotic band syndrome.

There are two main hypotheses for the pathogenesis of amniotic band syndrome. The 'exogenous' hypothesis postulates that following a tear in the amnion, fibrous amniotic bands produce constrictions around extremities that may