



This month – 5 cases:

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|------------------------------|------|--------------------------|------|
| 1. Pus-Filled Bumps | p.35 | 4. A Blood-Filled Lesion | p.39 |
| 2. A Red Mass | p.36 | 5. Itchy Eruption | p.40 |
| 3. Flattened Globose Papules | p.38 | | |

Case 1

Pus-Filled Bumps

You are asked to see a 12-month-old toddler with yellow bumps on his feet for eight months. The mother notes that they seem itchy for him but he is otherwise well with no fever or systemic symptoms. The lesions began as red dots that progressed to pus-filled bumps. They seem to come up in crops every few weeks.

What is your diagnosis?

- Acropustulosis of infancy
- Recurrent herpes simplex infections
- Methicillin resistant *Staphylococcus aureus* infections
- Pustular psoriasis
- Incontinentia pigmenti

Answer

Acropustulosis of infancy (**answer a**) is an idiopathic pustular disorder with onset usually between birth and two-years-of-age, characterized by recurrent, pruritic, vesiculopustular lesions that recur every few weeks to months. The characteristic presentation and course of acropustulosis of infancy is usually distinctive enough to make the diagnosis. However, when in doubt, a smear of pustule contents reveals large numbers of neutrophils and occasionally eosinophils. Some cases of acropustulosis have been associated with preceding scabies infections.

With time, patients with acropustulosis of infancy experience fewer and less intense flares of their lesions. Generally, the entire process resolves within



two to three years. Treatment is aimed at controlling the associated pruritis and may involve systemic antihistamines and topical corticosteroids.

The recurrent lesions with no systemic symptoms make methicillin resistant *Staphylococcus aureus* and herpes infections less likely. Pustular psoriasis is rare in this age group. Incontinentia pigmenti is unlikely in a male child and the pustular stage resolves in the first few months of life.

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Case 2

A Red Mass

A 14-month-old child presents with a reddish mass on the right side of the abdomen. The mass was not apparent at birth. It appeared as a telangiectatic patch at one-month-old.

What is your diagnosis?

- a. Port-wine stain
- b. Venous malformation
- c. Salmon patch
- d. Infantile hemangioma

Answer

An infantile hemangioma (**answer d**) usually appears in the first few weeks of life as an area of pallor, followed by telangiectasis. The lesion grows rapidly in the first three to six months of life. Superficial lesions are bright red, protuberant and sharply demarcated and are often referred to as “strawberry hemangiomas” or “capillary hemangiomas.” Deep lesions are bluish and dome-shaped. An infantile hemangioma consists of collections of dilated vessels surrounded by proliferating endothelial cells. An infantile hemangioma continues to grow until nine- to 12-months-of-age, at which time the growth rate slows down to parallel growth of the child. Involution begins in most cases by the time the child is three- to four-years-old. A central graying of the lesion and shrinkage in size are the visible stages of this process. Half of these lesions will show complete involution by the time a child reaches age five; 70% will have disappeared by age seven and 95% will have regressed by ages 10 to 12. When involution is complete, the skin looks completely normal; however, partial involution may leave an atrophic scar with a few telangiectatic vessels.



The majority of infantile hemangiomas require no treatment. Indications for active intervention include:

- severe or recurrent hemorrhage unresponsive to treatment,
- threatening ulceration in areas where serious complications might ensue,
- interference with vital structures and
- significant disfigurement.

Treatment options include systemic or intralesional corticosteroids, interferon- α , pulsed dye laser and surgical resection.

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Case 3

Flattened Globose Papules

An 18-year-old gentleman presented with these lesions, which occurred a few days after he had unprotected sex with a new partner.

What is your diagnosis?

- a. Folliculitis
- b. Impetigo
- c. Molluscum contagiosum
- d. Deep mycosis

Answer

Molluscum contagiosum (MC) (answer c) is an asymptomatic condition. Lesions are skin-coloured, white, or slightly pink, flattened globose papules, 3 mm to 6 mm in diameter, many with a small central aperture or dell. The surface is “semi gloss,” pearl-like and waxy. Lesions may occur singly or in groups. Groin and genitalia are commonly involved in sexually active persons. Lesions undergoing spontaneous resolution often become acutely inflamed. Facial involvement in adults usually indicates concomitant HIV infection. Lesions in these cases may become very large and run together. MC is a viral infection, is common in children and young adults and is spread by skin-to-skin contact.

The distinctive appearance of MC usually suffices. Direct examination of the whitish, curd-like content of the lesions mounted in 15% potassium hydroxide solution, or smeared on a slide and Giemsa-stained, shows the large intracytoplasmic inclusions characteristic of the disease (molluscum bodies). Atypical presentations in immunocompromised patients need punch or shave biopsy confirmation.



Lesions few in number can be curetted easily. Anesthesia is seldom necessary. Cryotherapy with liquid nitrogen is effective. More aggressive treatment is indicated in immunocompromised patients. Laser ablation, as well as electrodesiccation and curettage are producers of choice.

For children, the prognosis is excellent. Resolution of MC even without treatment usually occurs in three to nine months. For HIV-infected persons, the prognosis is guarded. Many cases are resistant even to aggressive treatment.

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Case 4

A Blood-Filled Lesion

A 78-year-old man presented with an asymptomatic dark blue-to-violaceous compressible papule, 1.4 cm in diameter, which is very slowly increasing in size over the last 25 years.

What is your diagnosis?

- a. Blue nevi
- b. Venous lake
- c. Basal cell carcinoma
- d. Malignant melanoma

Answer

Venous lake (**answer b**) is a dark blue, slightly elevated lesion composed of a dilated, blood-filled vascular channel. They occasionally bleed after trauma. Venous lakes represent a form of vascular ectasia (vascular dilatation). This group of diseases also includes spider angiomas and telangiectases. A capillary aneurysm is considered a precursor or variant of a venous lake.

The development of venous lakes is believed to be exacerbated by solar exposure and damage. One theory is that chronic solar damage injures the vascular adventitia and the dermal elastic tissue, permitting dilatation of superficial venous structures. Vascular thrombosis may also play a role in the development of these lesions because thrombosis is commonly present in lesions of this type. Whether thrombosis is a primary or a secondary event in the development of these lesions is unclear.

Venous lakes have been reported only in adults and usually occur in patients > 50-years-of-age. Lesions are typically distributed on the sun-exposed surfaces of the face and neck, especially on the helix



and antihelix of the ear and the posterior aspect of the pinna. Another common site of involvement is the vermilion border of the lower lip. Sometimes, several lesions are found on the same person and the surrounding skin reveals actinic damage. Solar elastosis is believed to contribute to the development of venous lakes via alteration of vascular and dermal elastic fibers.

Punch or shave biopsy can be used to obtain a specimen for pathologic confirmation of diagnosis. Treatment usually is performed for cosmetic reasons or to alleviate recurrent bleeding. Venous lakes can be treated by excision, laser, electrodesiccation or cryosurgery.

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Case 5

Itchy Eruption

This 11-year-old girl has complained of an itchy eruption on the anterior soles and pulps of her toes for the past two winters and to a lesser degree during the summer.



What is your diagnosis?

- a. Tinea pedis
- b. Bacterial erosions of the soles
- c. Dyshidrotic eczema
- d. Contact dermatitis
- e. Juvenile plantar dermatosis

Answer

Juvenile plantar dermatosis (**answer e**) is a scaly, glazed, often fissuring eruption of the anterior soles and toe pulps. It mainly occurs in prepubertal children. It is rarely on the dorsum of the foot. Often there is an atopic association.

The condition is thought to be due to sweating in boots or in impermeable socks or shoes followed by the rapid drying of the skin once this apparel is removed.

Treatment involves education regarding the use of proper footwear and lubricating the feet as soon as possible once the footwear has been removed. Products such as Vaseline® or a mild steroid ointment are useful. The condition itself ceases to be a problem after puberty as it is thought that the thicker plantar skin in an adult prevents the rapid drying effect.

As an interesting side note, this condition was first described by a Dermatologist from Calgary, Alberta, Dr. Tom Enta, in a paper entitled Peridigital Dermatitis in Children.¹

Reference

1. Enta T: Peridigital Dermatitis in Children. *Cutis* 1972; 10:325-28.



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OMNARIS is indicated for the treatment of seasonal allergic rhinitis, including hayfever, and perennial allergic rhinitis in adults and adolescents 12 years of age and older.

OMNARIS is contraindicated in patients with a hypersensitivity to any of the ingredients. OMNARIS should be used with caution, if at all, in patients with active or quiescent tuberculosis infections of the respiratory tract.

The most common adverse reactions with OMNARIS reported in short-term clinical trials of SAR and PAR in patients 12 years of age and older were epistaxis (2.7% vs. 2.1% placebo), nasal passage irritation (2.4% vs. 2.2% placebo) and headache (1.3% vs. 0.7% placebo).

The most common adverse reactions with OMNARIS reported in a 52-week clinical trial of PAR in patients 12 years of age and older were epistaxis (8.4% vs. 6.3% placebo), nasal passage irritation (4.3% vs. 3.6% placebo) and headache (1.6% vs. 0.5% placebo).

OMNARIS should be used with caution, if at all, in patients with untreated local or systemic fungal or bacterial infections; systemic viral or parasitic infections; or ocular herpes simplex. Patients who are on drugs that suppress the immune system are more susceptible to infections than healthy individuals. Because of the inhibitory effect of corticosteroids on wound healing, patients who have experienced recent nasal septal ulcers, nasal surgery, or nasal trauma should not use a nasal corticosteroid until healing has occurred. Rarely, immediate hypersensitivity reactions or contact dermatitis may occur after the administration of intranasal corticosteroids. Rare instances of wheezing, nasal septum perforation, cataracts, glaucoma, and increased intraocular pressure have been reported following the intranasal application of corticosteroids. To minimize the systemic effects of intranasal corticosteroids each patient should be titrated to his/her lowest effective dose. In patients who have asthma or other clinical conditions requiring long-term systemic corticosteroid treatment, rapid decreases in systemic corticosteroid dosages may cause severe exacerbation of their symptoms. There are no adequate studies with OMNARIS in pregnant women. It is unknown if ciclesonide is excreted in human milk.

Product monograph available upon request.

*Mean change in average reflective AM and PM total nasal symptom score: after 2 weeks in SAR – OMNARIS -2.40 vs. -1.50 placebo, $p < 0.001$; after 6 weeks in PAR – OMNARIS -2.51 vs. -1.89 placebo, $p < 0.001$.