

QUIZ SECTION

Acute Disseminated Erythematous Papulovesicular Skin Lesions in a 7-year-old Child: A Quiz

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A 7-year-old girl presented with moderately pruritic cutaneous lesions that had developed suddenly a week previously and that were accompanied by subfebrility in the evenings (Fig. 1). In addition, tense blisters were found on the hands and feet, including the palms and soles. The face and mucous membranes were not affected. The patient had not suffered from previous illness, atopy or infections and had not received any recent vaccinations. A physical examination revealed no other pathological findings. Laboratory tests, including a blood cell count and measurement of serum C-reactive protein levels, revealed no abnormalities. Bullous autoimmune dermatoses were excluded by the re-

sults of direct and indirect immunofluorescence analyses. A punch biopsy of the leg was performed. The epidermis displayed focal acanthosis with spongiosis and pseudo-Pautrier abscesses. A moderate superficial perivascular infiltrate of lymphocytes and small numbers of eosinophils was also present. Oral corticosteroid (methylprednisolone; initial dose 32 mg/day – subsequently reduced) and an oral antihistamine were administered, and an antiseptic cream (triclosan 2%) was applied topically. The skin lesions subsided within a week without relapse.

What is your diagnosis? See next page for answer.



Fig. 1. Multiple erythematous papules and plaques, partially excoriated and covered by yellowish crusts, and mainly located on the limbs and buttocks. Tense blisters were found on the hands and feet.

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ANSWERS TO QUIZ

Acute Disseminated Erythematous Papulovesicular Skin Lesions in a 7-year-old Child: A Comment

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Diagnosis: Vesicular Gianotti-Crosti syndrome

Gianotti-Crosti syndrome (GCS) is an acute, self-limiting acrolocated disease, characterised by symmetric erythematopapular eruptions on the cheeks, buttocks and limbs (1). GCS usually occurs in the context of viral infection, or after the administration of vaccines (2). It was originally described by Crosti and Gianotti in 1956. They identified two disease patterns: papular acrodermatitis in childhood, in association with a hepatitis B virus (HBV) infection, and a papulovesicular acrolocated syndrome, associated with viruses other than HBV (1). In the early 1990's, Caputo et al. (3) concluded that it was impossible to differentiate these two patterns clinically and referred to them jointly as GCS.

GCS affects both sexes equally. It primarily occurs in children between the ages of 3 months and 15 years, with most cases occurring in children under the age of 6. However, GCS has also been described in adults (4, 5). The pathogenesis of the disease is still unknown. A case-controlled study found a significant relationship between GCS and atopy or family history of atopy (6). However, no atopy was found in our patient.

Various viruses and vaccines can cause GCS. Due to anti-HBV immunisation, Epstein-Barr virus is the most common underlying infection today. In many cases, identification of a causative virus is not successful. In terms of vaccine-related GCS, it has been reported that patients tolerate subsequent booster vaccinations without any problems (7). GCS is diagnosed clinically. Truncal involvement, as was noted in our patient, is not an exclusion criterion (8).

Non-cutaneous findings include lymphadenopathy and, occasionally, hepato- or splenomegaly. Laboratory investigations can be helpful in identifying the causative viral antigen, even if GCS is sometimes the only clinical manifestation (9).

Microscopic examinations may be useful in the diagnosis of GCS. As tense bullae were found on the hands and feet of our patient, a skin biopsy was performed and

analysed by direct and indirect immunofluorescence. The results of these analyses excluded the diagnosis of bullous autoimmune dermatoses. Further histological analyses revealed acanthosis and spongiosis, as well as a superficial perivascular and interstitial infiltrate of lymphocytes and limited numbers of eosinophils, as has been described in other reports of GCS (4).

GCS is a self-limiting disease that lasts for between 10 and 60 days. Treatment is only necessary to relieve clinical symptoms such as blistering/crusting, as well as severe pruritus. Topical corticosteroids and, in severe cases, systemic corticosteroids can be administered (10).

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