REFERENCES

1. Davies, M. G., Greaves, M. W., Coutts, A. & Black, A. K.: Nevus oligemicus. A variant of nevus anemicus. Arch Dermatol *117:* 111, 1981.
2. Greaves, M. W., Birkett, D. & Johnson, C.: Nevus anemicus: a unique catecholamine-dependent nevus. Arch Dermatol *102:* 172, 1970.
3. Waterstan, D. quoted by Sinclair, D. Psychophysiology of cutaneous sensation. *In* Jarret, A.: The Physiology and Pathophysiology of the Skin. Vol. 2, 448 pp. Academic Press, London and New York, 1973.

Herpes Zoster in a 6-month-old Infant

Inkeri Helander,[1] Pertti Arstila and Pertti Terho

Departments of [1]Dermatology and Virology, University of Turku, SF-20520 Turku 52, Finland

Received July 14, 1982

Abstract. A case of herpes zoster occurring in infancy is reported. The clinical picture was characteristic and the virological studies confirmed the diagnosis. The course was uneventful. The mother had varicella during the second trimester of pregnancy. This report is in accordance with the notes that herpes zoster in infancy is benign and the recovery is rapid and without sequelae.

Varicella and zoster are caused by the same virus, *Herpes varicellae*. Varicella is the primary infection with *H. varicellae*, whereas zoster is the result of reactivation of residual latent infection, usually of sensory neurones, infected by the viraemia of chicken pox. The virus can replicate and invade the sensory nerve and the skin around the sensory nerve endings. This mechanism explains the typical lesions, clusters of vesicles on an erythematous base of the area of the dermatome (7).

Maternal varicella may result in one of the following three clinical syndromes: early onset of postnatal varicella which may vary from a typical varicella to a fatal disseminated infection (3); intrauterine infection may rarely lead to severely affected infants who may display multiple congenital anomalies (3, 6); or herpes zoster, which may appear months or years after birth (1, 2, 4, 8, 9, 10).

We present a case of herpes zoster in a 6-month-old infant, whose mother had varicella during the second trimester of the gestation.

REPORT OF A CASE

A 6-month-old infant was brought to the Department of Dermatology of the University Central Hospital of Turku because of a rash characterized by groups of vesicles on an erythematous base situated along the distribution of the right dermatome C 2. The infant was otherwise asymptomatic. The typical zoster rash resolved in 2 weeks. The mother's sister and her son, who had visited the home at the beginning of the herpes zoster infection of our patient, showed the typical varicella infection 2 weeks later.

Virological findings

Virus isolation was attempted from a typical vesicle with fluid, but it was negative. Indirect immunofluorescence against varicella-zoster in the cells scraped from the bottom of the vesicles was positive (with some fluorescence against herpes simplex, probably due to cross-reaction).

In the complement-fixation test, no antibodies were measurable to VZ in the mother or the infant at the time of eruption, 6 months after parturition. However, in radioimmunoassay of VZ-specific IgG class antibodies both the mother and the child were seropositive, as also were the contacts. On the other hand, herpes simplex antibodies were found only in the mother's sister by radioimmunoassay.

COMMENT

Although transplacental passage of VZV from mother to fetus is probably a rather frequent event in cases of varicella during pregnancy (5), the low incidence of congenital varicella syndrome shows that the fetus is relatively resistant to infection. Some immunological disorder in the mother could therefore be assumed to be a co-factor for the development of the infection in the fetus.

Our patient was exposed to varicella *in utero*. The clinical picture, the spread of virus to relatives from the index case and the virological studies confirmed that the infant suffered from herpes zoster. The appearance of the zoster in the 6-month-old infant coincided with the disappearance of the transplacentally acquired VZ antibodies.

This report is in accordance with the notes that herpes zoster in infancy is benign and that the recovery is rapid and without sequelae. Our report further documents one aspect of the relationship between the maternal varicella and the occurrence of herpes zoster early in life.

REFERENCES

1. Brazin, S. A., Simkovich, J. W. & Johnson, W. T.: Herpes zoster during pregnancy. Obstet Gynecol *53 (2):* 175–181, 1979.
2. David, T. J. & Williams, M. L.: Herpes zoster in infancy. Scand J Infect Dis *11:* 185–186, 1979.
3. DeNicola, L. K. & Hanshaw, J. B.: Congenital and neonatal varicella. J Pediatr *94:* 175–176, 1979.
4. Dworsky, M., Whitley, R. & Alford, C.: Herpes zoster in early infancy. Am J Dis Child *134:* 618–619, 1980.
5. Gershon, A. A.: Varicella in mother and infant: problems old and new. *In* Infections of the Fetus and Newborn. Progress in Clinical and Biological Research (ed. S. Krugman & A. A. Gershon), vol. 3, pp. 79–95. Alan R. Liss, New York, 1975.
6. Hanshaw, J. B. & Dudgeon, J. A.: Viral diseases of the fetus and newborn. Introduction. *In* Major Problems in Clinical Pediatrics, vol. 17, pp. 1–9. W. B. Saunders Company, Philadelphia, 1978.
7. Hope-Simpson, R. E.: The nature of herpes zoster: a long-term study and a new hypothesis. Proc R Soc Med *58:* 9–20, 1965.
8. Kouvalainen, K., Salmi, A. & Salmi, T. T.: Infantile herpes zoster. Scand J Infect Dis *4:* 91–96, 1972.
9. Laude, T. A. & Rajkumar, S.: Herpes zoster in a 4-month-old infant. Arch Dermatol *116:* 160, 1980.
10. Taranger, J., Blomberg, J. & Strannegård, Ö.: Intrauterine varicella: a report of two cases associated with hyper-A-immunoglobulinemia. Scand J Infect Dis *13:* 297–300, 1981.

Keratodermia punctata hereditaria Treated with Etretinate (Tigason)

Jørgen V. Christiansen

Department of Dermatology, Marselisborg Hospital, University of Aarhus, Aarhus, Denmark

Received August 10, 1982

Abstract. Nine patients with keratodermia punctata hereditaria were treated with etretinate 0.5 mg/l mg/kg/day for 3 to 13 months. The result was good to moderate in 7 of the 9 patients.

Key words: Keratodermia punctata hereditaria; Etretinate (Tigason)

Bergfeld et al. (1) treated 6 patients with keratosis palmaris et plantaris with isotretinoin, with good results in 5 of 9 patients after 8 to 12 weeks observation period. We have treated 9 patients with keratodermia punctata hereditaria with etretinate (Tigason).

MATERIAL AND METHODS

Nine patients, 4 men and 5 women, were treated for 3 to 39 months with etretinate 0.5 mg/l mg/kg/day. The mean age of the group was 57 years. Measurements of safety and efficacy were made at monthly intervals.

RESULTS

The results were good in 3 patients, moderate in 4, and there was no effect in 2 patients. The treatment was stopped in 6 of 9 patients after 3 to 13 months. One man and 2 women had continued treatment up to 39 months.

Side effects

All the patients had some dryness of the mucous membranes, one man and 2 women had some defluvium and one man and one woman had some pruritus. There was no increase in liver transaminases during the treatment.

DISCUSSION

The treatment of all types of hereditary keratodermia has been unrewarding in the past. We now seem to have some prospect of helping these patients. There seems to be almost the same positive outcome with etretinate as found with isotretinoin. In most cases the treatment had to be continued for a rather long time, but patients seem to tolerate the treatment rather well.

REFERENCE

1. Bergfeld, W. F., Derbes, V. J., Elias, P. M., Frost, P., Greer, K. E. & Shupack J. L.: The treatment of keratosis palmaris et plantaris with isotretinoin. Am Acad Dermatol *6:* 727, 1982.

Ear Ache during Etretinate Treatment

Lennart Juhlin

Department of Dermatology, University Hospital, Uppsala, Sweden

Received August 2, 1982

Abstract. Two patients with ear ache related to etretinate treatment in a dose of 50–75 mg are reported. The ache disappeared within a week after lowering the dose and reappeared when the dose was increased.

Key words: Etretinate; Ear ache; Side effects