Onychomadesis

A 2-year-old girl developed Hand, foot, and mouth disease (HFMD) with a self-limiting episode of fever, palmoplantar vesicular lesions and small aphthoid ulcerations of the oral mucosa. Approximately one month later, she presented with onychomadesis of all fingernails of both hands (***Figs.* 1** *and* **2**). About six weeks later, complete resolution occurred spontaneously.

Onychomadesis is a reversible, painless, non-inflammatory condition in which there is proximal shedding of the nail plate from the nail matrix. It can occur in fingernails, toenails or both. It may be secondary to systemic disorders, high fevers, bullous dermatoses, Kawasaki disease, infections (streptococcal infections and measles), zinc deficiency, local trauma, acute paronychia, and drug reactions. In addition to these causes, many cases are idiopathic. HFMD is a common pediatric viral illness that is characterized by vesicular eruptions that involve the palms, the soles, and the oral cavity. The median latency period between HFMD and onychomadesis is 40 days. The mechanism of nail matrix arrest after infection remains unclear. Transverse leukonychia and Beau lines reflects milder interruptions in ungula growth and may occur simultaneously in the same patient or a result of the same disease process.

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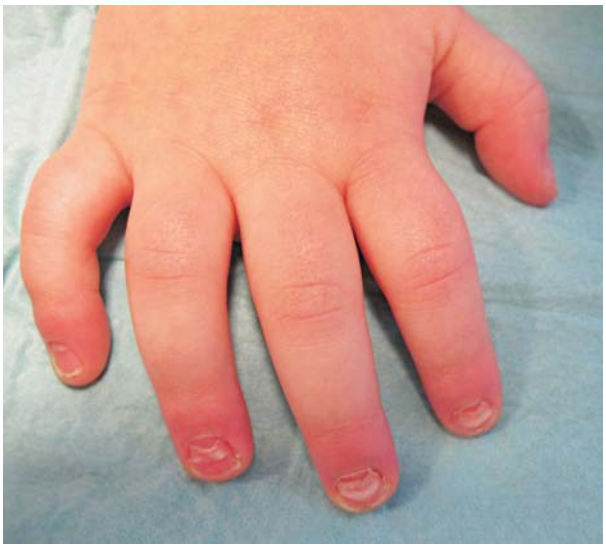

Fig. 1 *Onychomadesis of all fingernails of the right hand.*

Fig. 2 *Nail plate shedding on the first, second, third and fourth fingers of the left hand.*

Acute Hemorrhagic Edema of Infancy

A 14-month-old girl presented with acute onset erythematous skin eruption on her body, following an episode of upper respiratory tract infection. On examination, the child was febrile and the vitals were stable. There were multiple, non-tender, purpuric targetoid lesions studded with vesicles on her face, pinna, extremities and buttocks. The mucosa and the trunk were spared. There was mild non-pitting edema over the upper extremities and the face. Systemic examination was normal. Routine blood examination, coagulation profile, renal function tests, blood culture, and urine analysis were normal, except for mild leucocytosis (total leukocyte count 12,600 mm^3). Histopathlogical examination from the lesion showed features of leucocytoclastic vasculitis. A diagnosis of Acute hemorrhagic oedema of infancy (AHEI) was made. Fever subsided in two days and the skin lesions completely subsided within the next two weeks.