Solitary Molluscum Contagiosum

A 7-year-old girl presented with solitary, asymptomatic, nodule near right angle of mouth for 8 months. The lesion started as a small papule and increased in size over time. The child was otherwise healthy. On examination, single erythematous nodule measuring 1 cm, and of soft to firm consistency, was seen near the right angle of mouth. The top of the lesion was eroded and covered with crust. Rest of the muco-cutaneous examination was unremarkable (***Fig.* 1**). During examination, whitish paste like material was expressed during palpation. Giemsa stain of the material showed faint bluish cytoplasmic inclusions (***Fig.* 2**). The lesion was removed by shave excision and was sent for histopathology. The histopathology findings were acanthosis and eosionphilic cytoplasmic inclusions, confirming the diagnosis of molluscum contagiosum. Family members were examined and classical molluscum contagiosum lesions were noted in brother (left temple region) and mother (abdomen). After shave excision, oral and topical antibiotic was advised for 7 days; the lesion resolved completely in 2 weeks, without any sequale.

Solitary molluscum contagiosum poses a diagnostic challenge and is confused with keratoacanthoma (firm lesion with central keratin material) and granuloma pyogenicum (soft friable lesion with history of bleeding on minor trauma or spontaneously). Cytopathology can be helpful in rapid diagnosis of such lesions.

FIG. 1 *Erythematous crusted nodule at the angle of mouth.*

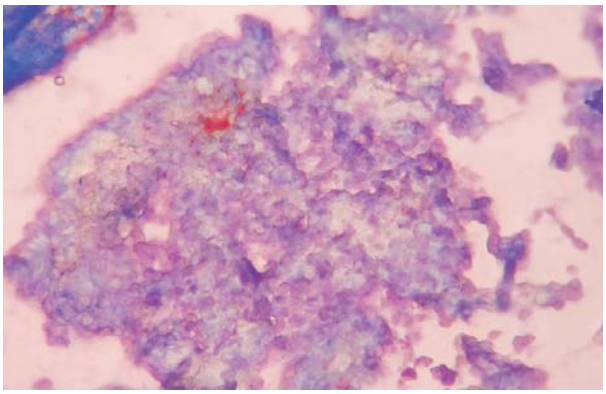

FIG. 2 *Pale blue cytoplasmic inclusions (Giemsa stain X 400).*

***PIYUSH KUMAR AND SUSHIL S SAVANT**
Department of Dermatology,
Katihar Medical College,
Katihar, Bihar, India.
**docpiyush@gmail.com*

Neonatal Milia

A full-term female neonate born by emergency lower segment Caesarean section (for the indication of breech in labor) was referred to us for evaluation of a profuse eruption of white lesions on her face. On examination, a profuse eruption of shiny, pearly white papules was noted on chin, forehead, cheeks and nose (***Fig.* 1**). Mild hypertrichosis was also present on face. Rest of the mucocutaneous examination was normal. No specific treatment was prescribed. At a follow-up visit, all the lesions had completely resolved. Based on the classic presentation and natural resolution of the lesions, a clinical diagnosis of neonatal milia was made.

Milia are one of the most common transient skin disorders in neonates being present in up to 30-50% of neonates. These consist of 1-2 mm white or yellowish papules on the face; the nose is usually predominantly affected. Less commonly, trunk and extremities are also involved. Milia are epidermal keratin cysts developing in connection with the pilosebaceous follicle. Similar inclusion cysts may also be seen on the palate (known as

FIG. 1 *Shiny, pearly white papules on chin, forehead, cheeks and nose.*

Epstein pearls); when they occur on the alveolar margins, they are termed Bohn nodules. Main differential diagnoses of milia include sebaceous hyperplasia (more yellow), molluscum contagiosum (dome-shaped papules with central umbilication), miliaria crystallina (skin-colored pin-pint clear vesicles), bacterial and candidal lesions, and transient neonatal pustular melanosis (superficial vesiclopustules that are present at birth, rupture within 24-48 hours and heal with hyperpigmented macules). No treatment is required for neonatal milia as these spontaneously resolve in a few weeks.

***NAVEEN KUMAR KANSAL AND SAURABH AGARWAL**
Department of Dermatology and Venereology
Government Medical College
Haldwani, Nainital, India
**kansalnaveen@gmail.com*

Leprechaunism (Donohue Syndrome)

Born at term with a birth weight of 1700 g to consanguineous parents, this 4½-month-old girl weighed 2900 g with a length of 52 cm and head circumference of 34 cm. She appeared markedly emaciated, and had hirsuitism, thickened skin with patchy hyperpigmentation, coarse facial features, sunken cheeks, pointed chin, flared nostrils, broad open mouth, thick lips, low-set ears, enlarged breasts and clitoromegaly. Her investigations revealed massively enlarged polycystic ovaries, elevated estradiol and testosterone levels, hypoglycemia (blood glucose 27 mg/dL) and hyperinsulinemia (serum insulin of 253 µU/mL). Leprechaunism was diagnosed on the basis of these clinical features and laboratory findings. In view of the poor prognosis and young age, this patient was given symptomatic treatment. She succumbed to pneumonia and septicemia by 6 months of age.

Leprechaunism (Donohue syndrome) is a recessively inherited syndrome of insulin resistance with severe prenatal and postnatal growth retardation, ovarian hyperstimulation, acanthosis nigricans and abnormal facial features, as described above. Over 50 insulin receptor mutations have been described which result in profound insulin resistance and altered glucose homeostasis with fasting hypoglycemia and postprandial hyperglycemia. Almost all affected patients die before two years of age. Other congenital syndromes of insulin resistance are Type A syndrome and Rabson-Mendenhall syndrome in which growth retardation is less severe, and severe symptoms are not seen in early infancy.

***URMI GHOSH AND SARAH MATHAI**
Department of Pediatrics and Pediatric Endocrinology,
Christian Medical College, Vellore,
Tamil Nadu, India.
**uurmighosh@yahoo.co.in*

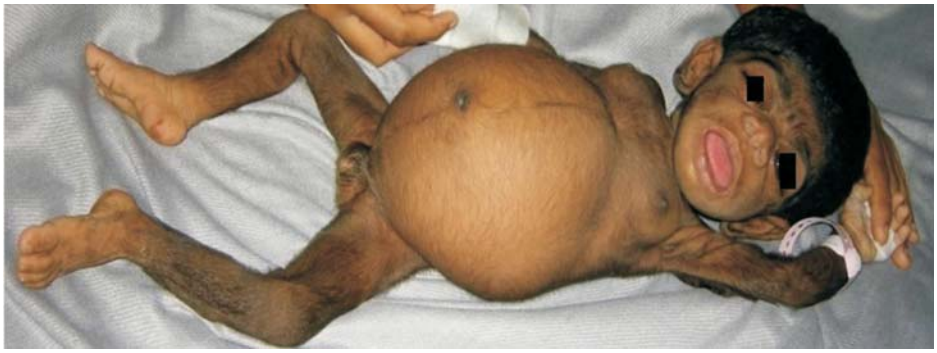

FIG. 1 *Hirsuitism, marked emaciation and coarse facial features in Leprechaunism.*