

Genital lesions began to improve after two days of treatment.

Genital lesions caused by herpes simplex virus are rare in children and adolescents, who are not sexually active. The main differential diagnosis is vulvo-vaginal candidiasis, which is characterized by the pruritus and raspberry aspect of the inguinal folds surmounted by whitish coating. In the presence of a clump of painful

vesicles associated with inguinal adenopathy, the diagnosis of genital herpes is very likely.

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## Porokeratotic Eccrine Ostial and Dermal Duct Nevus

A 3-year-old girl presented to us for a rough aspect of the trunk. Dermatologic examination showed multiple rough papules in the upper and lower limbs (**Fig. 1a**), extending to the trunk (**Fig. 1b**) and upper limbs with a linear arrangement, and then to the face (**Fig. 1c**). We also found a focal palmoplantar keratoderma distributed in small islands. According to the clinical aspect of the lesions, we suspected porokeratosis that was confirmed by the skin biopsy. She was treated by acitretin (0.25 mg/kg/day) with good evolution within 3 months.

Porokeratotic eccrine ostial and dermal duct nevus (PEODDN) is a rare variant of porokeratosis due to a mutation in *GJB2* gene coding for the connexin 26 junction protein. PEODDN can present as multiple hyperkeratotic or atrophic papules grouped on plaques with a blaszko linear arrangement. These lesions are mainly located at the extremities and are frequently associated with a palmoplantar involvement. Proximal involvement of the extremities, the trunk and the face, as seen in this patient is very rare. The pathognomonic histological findings are characterized by cornoid lamella located in relation of a dilated sweat excretor canals and associated to vacuolated keratinocytes in the epidermic invagination. Differential

diagnoses include Linear porokeratosis, linear lichen planus, linear verrucous epidermal nevus, and linear Darier's disease. PEODDN start at birth or in the early childhood. Clinically it resembles a comedonal nevus, but it occurs on the palms and soles where pilosebaceous follicles are normally absent. Treatment options include



**FIG.1** (a) Multiple papules in the upper limbs with a linear arrangement; (b) Multiple rough papules in the trunk; and (c) Extended lesions to the trunk and the face.

dermocorticoids, topical calcipotriol, cryotherapy, CO<sub>2</sub> laser, photodynamic therapy and retinoids.

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