Green Pigmented Teeth

A male child born with rhesus-isoimmunisation was treated with double volume exchange transfusion followed by phototherapy for 96 hours. On day 10, he was found to have conjugated hyperbilirubinemia which gradually progressed (maximum value, 42 mg/dL; conjugated fraction, 32 mg/dL on day 30). Hepatobiliary-iminodiacetic-acid (HIDA) scan showed delayed clearance. He received phenobarbitone for five days, keeping the possibility of inspissated bile plug syndrome. Gradually the bilirubin level decreased to 6mg/dl by 2 months of age. The baby had eruption of deciduous teeth at 7 months of age which were green-to-black stained. At current age of 18 months, all the teeth are green-to-black stained (***Fig.* 1**).

FIG.1 *Green-to-black stained deciduous teeth.*

Hyperbilirubinemia causes reversible staining of all tissues except the teeth. In the latter, bilirubin is permanently trapped because of loss of metabolic activity after maturation. Differential diagnosis of green teeth includes – neonatal cholestasis (*e.g.*, biliary atresia, sepsis, pathological hyperbilirubinemias, and metabolic diseases), hemolytic-anemia, congenital hyporthyroidism, hepato-biliary problems, and drug administration. Treatment options include; composite resin restorations, bleaching techniques, and use of transillumination with ultraviolet light.

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Erythematous Vesicular Lesion

An eleven- year -old boy presented with erythematous lesion over the left post auricular region for one day. There was history of an insect seen over the area of rash on previous night. On examination, he was afebrile and had erythematous rash with vesicles over the posterior aspect of the left auricle and mastoid area (**Fig. 1**). The findings of systemic examinations were normal. His complete blood count was within normal limits. Based on the history, presence of typical kissing lesions a diagnosis of paederus dermatitis was made. The child was treated with topical steroid ointment. Skin lesions healed completely within one week.

FIG.1 *Vesicles over auricle.*

Paederus beetles have been associated with outbreak of dermatitis in various countries. Adult of these beetles are usually 7-10 mm long and 0.5 mm wide. They have black head and red thorax. Dermatitis is caused by paederine which is released on crushing the insect on the skin. The rash appears 24 hours after contact. A striking feature is the presence of kissing lesions that occur wherever apposition of skin is possible (*e.g.* flexure of the elbow, adjacent surfaces of the thigh). Clinical appearance of paederus dermatitis may be confused with herpes zoster, acute allergic contact dermatitis, liquid burns, millipede dermatitis and phytophoto dermatitis. There are many similarities between paederus dermatitis and phytophoto dermatitis including linear asymmetric areas of erthyema, possible blister formation and dyspigmentation. With phytophoto dermatitis, there is a history of exposure to light sensitizing biological substance such as lime or fig. The characteristic linear appearance of the lesion, the presence of kissing lesions and their predilection for exposed areas differentiate paederus dermatitis from other above mentioned conditions. Histopathology may support the diagnosis of paederus dermatitis. The cases should be managed with initial washing the area with soap and water followed by topical steroid ointment.

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