

implicated in the pathogenesis. The condition clears off as the baby grows older. Treatment consists of removal of crusts with 3% salicylic acid; and application of low-potency steroids and antifungal agents. Clinical differentials include tinea capitis (easy pluckability of hairs), atopic dermatitis (presence of pityriasis alba, positive family history), impetigo (honey colored crust),

and psoriasis (scaly erythematous plaque with involvement of other sites and nails).

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## Nevus of Ota

A 6-year-old girl presented with an asymptomatic dark patch over the left side of her face. Her parents first noticed a small patch of bluish discoloration, when she was two-months-old, that gradually increased in size and became darker in color. On examination, mottled blue-gray macules were seen over the left cheek extending to the left temporal area (*Fig. 1*). In addition, two small blue-black spots were seen on the sclera of her left eye. Oral mucosa, hairs, and nails were normal. Systemic examination was non-contributory. Based on the distinct color, morphology, and location of the lesion, the condition was diagnosed as nevus of Ota.

Nevus of Ota is believed to occur due to migration arrest of melanocytes on their way to the epidermis from the neural crest. It typically occurs as a persistent, speckled, blue-black, or slate-gray hyperpigmentation in the distribution of the ophthalmic and maxillary division of the trigeminal nerve. The bluish color is due to scattering of light by dermal melanin (Tyndall phenomenon). Though mostly present at birth, it can also appear later; 80% of the cases occur in females. Unilateral involvement is seen in 95% of the cases. Patchy scleral pigmentation is seen in two-third of the cases. Pigmentation may also be seen in the oral mucosa, cornea,



**FIG. 1** Mottled blue-grey macules of Nevus of Ota.

pharynx, and nasal mucosa. The condition is generally benign and persists for life. The treatment of choice for the condition is laser surgery; cosmetic cover-up may also be used.

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## Ecthyma

An 8-year-old boy presented with a painful crusted lesion over the left forearm. Cutaneous examination revealed a solitary coin-sized, indurated, ulcerated, tender plaque with central brownish adherent crust and yellowish-brown dried exudates at the margin (*Fig. 1*). There was no preceding history of any insect or arthropod bite. The Gram stain from pus obtained from underneath the crust

revealed gram-positive cocci, and culture grew both Group A  $\beta$ -hemolytic streptococci and *Staphylococcus aureus*. A diagnosis of ecthyma was made; oral cefixime and topical mupirocin ointment were prescribed along with removal of crust using diluted white vinegar soaks. Complete healing with scarring occurred within 2 weeks.

Ecthyma denotes cutaneous bacterial infection that extends deep into the dermis and heals with scarring. It usually develops over disrupted skin on extremities and rapidly develops into a vesicopustule and finally a