Generalized Benign Acanthosis Nigricans

A 4-year-old girl, born of a non-consanguineous marriage with normal growth and developmental milestones, presented with asymptomatic generalized hyperpigmentation. It started spontaneously at the age of 2 years, around the neck and axilla, and spread insidiously to involve the other parts of body. The skin gradually became thickened and rugose. There was no history of drug intake, polyuria, polydypsia, loss of appetite, excess weight gain or loss. Cutaneous examination revealed generalized hyperpigmentation with thickening of skin, which was accentuated in the back and sides of the neck, axillae, groins, dorsal hands and flexural areas of knees and elbows. The characteristic velvety plaque with corrugated surface could be appreciated in the flexures (***Fig*.1**). Mucous membranes, palms, soles, hair, and nails were unremarkable. Routine investigations, thyroid profile, insulin level, lipid profile, complete liver and renal function tests, and oral glucose tolerance test were within normal limits. Histopathological examination revealed marked hyperkeratosis, acanthosis and papillomatosis and was consistent with diagnosis of acanthosis nigricans. Epidermolytic hyperkeratosis was excluded on the basis of absence of bullous lesions and histopathological findings. Absence of mucosal and systemic involvement, and velvety texture of lesions in our patient were against the diagnoses of hemochromatosis and Addison's disease.

Generalized acanthosis nigricans, as seen here is rare and is most commonly seen in adults with an underlying malignancy. Age of onset more than 40 years, symptomatic (generalized pruritus), rapid progression and involvement of atypical sites such as mucosa (tongue and lips), Palm ("Tripe palm") and soles are clinical indicators of underlying malignancy. These findings were absent in our patient. The treatment is directed towards treating the underlying cause that includes, either weight reduction, discontinuation of offending drugs, correction of endocrinological abnormality or underlying malignancy. Emollients, keratolytics (topical retinoids, salicylic acid, lactic acid, urea), calcipotriol, systemic retinoids, CO2 laser ablation, and long-pulsed alexandrite laser may improve appearance.

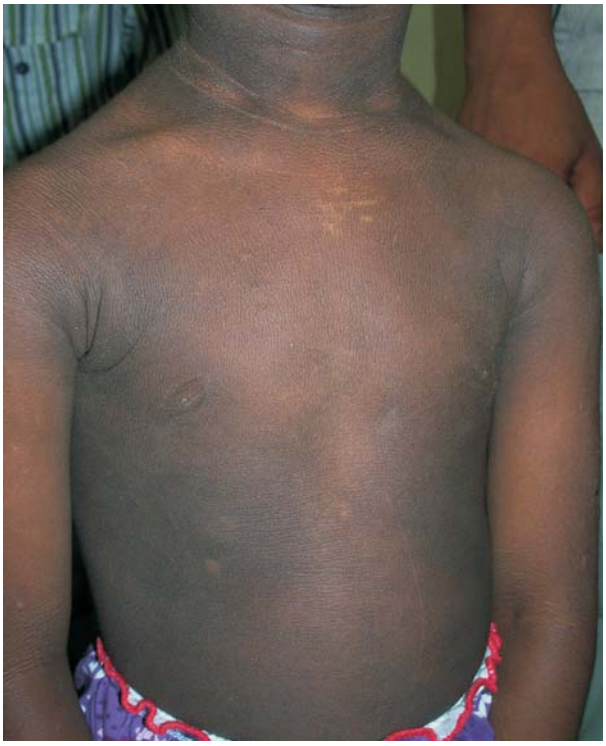

FIG.1 *Generalized hyperpigmentation associated with velvety skin thickening with corrugated surface.*

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An Infant with Skin Rash

An 8-month-old female with a history of eye discharge, presented with complaints of pustules on red tender skin, which ruptured to lead to erosions and peeling since 3 days. On examination, skin was tender with diffuse erythema. Whitish crusting and fissuring was seen in the perioral area and the neck (**Fig. 1**), with sparing of the mucosa. Flaccid pustules and blisters, few having ruptured to lead to erosions were seen on trunk, inner thighs and neck. Nikolsky sign was positive. Wrinkling of skin along with exfoliation was seen in the axillae. There was leucocytosis. Lesional pus for smear and culture sensitivity and blood culture were negative for *Staphylococcus.* Histopathology revealed focal loss of