Atypical Herpes Zoster

A 12-year-old girl – who was a diagnosed case of connective tissue disorder and was on oral prednisolone (2 mg/Kg/d) and hydroxychloroquine for 6 months – presented with multiple vesiculobullous eruptions over the right hand for 4 days. Eruptions started with tingling sensation and pain. On examination, she had steroid facies, hypertrichosis and hirsutism. Vesicobullous lesions were present on the dermatomal involvement of C8 and T1 (***Fig.* 1**). Investigations revealed normal blood counts erythrocyte sedimentation rate, C-reactive protein, liver function tests and renal function tests. Tzanck smear revealed multinucleated giant cells. A diagnosis of herpes zoster infection was made and patient was started on intravenous acyclovir (10mg/kg every 8 hrly); skin lesions healed within 7 days (***Fig.* 2**).

The diagnosis of herpes zoster is usually based on unilateral pain in a defined area accompanied by a typical rash in the dermatomal distribution of a segmental nerve. Manifestations of herpes zoster in immunocompromised children can be severe and life threatening. Patients with high risk for disseminated disease should receive intravenous acyclovir at 10 mg/kg every 8 hrly. Patients with uncomplicated herpes zoster and low risk for visceral dissemination should be treated with oral acyclovir, famciclovir or valacyclovir.

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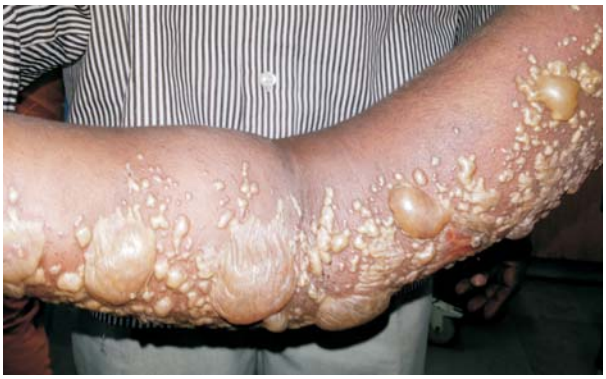

FIG. 1 *Vesiculobullous lesions over C_8 and T_1 dermatone.*

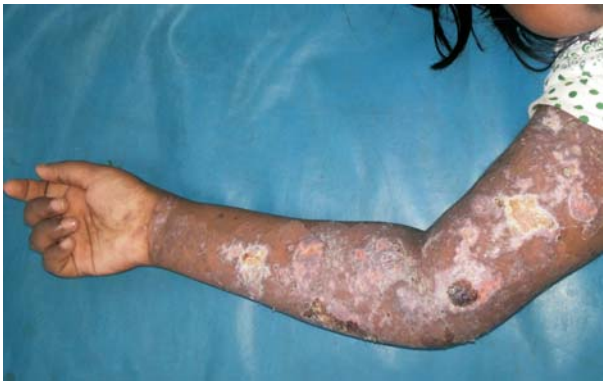

FIG. 2 *Lesions showing healing after 1 week of intravenous acyclovir.*

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Bohn's Nodules

A full term newborn boy, weighing 3 kg, born out of an uncomplicated pregnancy, was brought to us for evaluation of a few small, white and round bumps on the gingival surface. Examination of the oral cavity showed multiple, firm, pearly-white papules measuring 2 to 4 mm in diameter, grouped over the vestibular aspect of the alveolar ridge of the maxillary arch (***Fig.* 1**). Two similar lesions were seen on the mandibular area. These lesions were asymptomatic, non-tender, and fixed to the mucosa. Oral mucosa was otherwise normal. A few milia were noted on his chin. Detailed systemic examination was normal. No specific therapy was prescribed. Within a couple of months, most of the lesions subsided spontaneously. Based on the clinical features and the natural course of the disease, a diagnosis of Bohn's nodule was made.

Bohn's nodules are keratin cysts derived from remnants of odontogenic epithelium over the dental

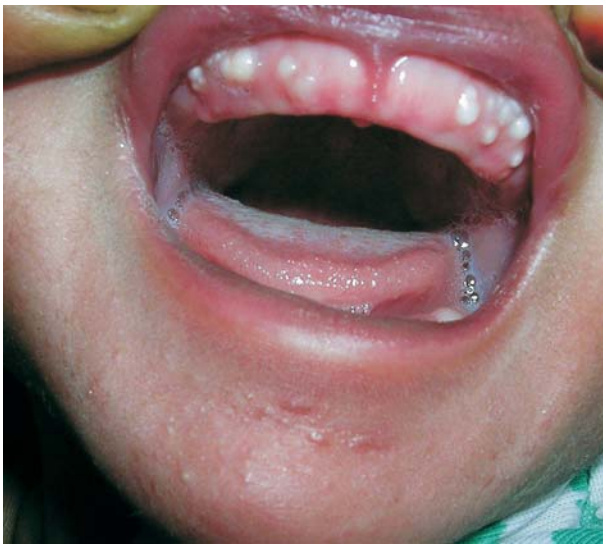

FIG. 1 *Pearly-white papules (Bohn's nodules) on alveolar ridge of a neonate.*

lamina or may be remnants of minor salivary glands. They occur on the alveolar ridge, more commonly on the maxillary than mandibular. Common differential diagnoses include other developmental oral inclusion cysts (Epstein pearl, Dental laminar cyst) and natal teeth. Epstein pearl is a small, firm, white, keratin-filled cyst, located on the mid palatine raphe. Dental laminar cyst (gingival cyst) is a yellow-white cystic lesion over the alveolar crest that arises from epithelial remnants of the degenerating dental lamina. Natal teeth usually erupt in the centre of mandibular ridge as central incisors. They have little root structure and are attached to the end of the gum by soft tissue.

Bohn's nodules usually rupture spontaneously and disappear within a few weeks to a few months. Counseling of the family members regarding its benign and self-limiting nature is all that is required in the management.

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Halo Nevus

A 7-year-old girl presented with a congenital blackish lesion over her forehead that had developed a white halo around it during the last three months. There was no history of white patches elsewhere over the skin. Examination revealed an oval hairy plaque of melanocytic nevus surrounded by a rim of depigmentation just above the left eyebrow (***Fig.* 1**). There were no other mucocutaneous or systemic abnormalities. A diagnosis of halo nevus was made and periodic follow-up was advised.

Halo nevus designates the development of a halo of hypomelanosis around a central cutaneous tumor. This tumor is usually a benign melanocytic nevus but rarely blue nevus, neurofibroma or malignant melanoma may show the halo phenomenon. Halo nevi presumably result from immunologically mediated host responses to a nevus. This is usually seen in children or young adults of either sex particularly on the trunk, less commonly on the head and rarely on the limbs. It occurs with increased frequency in patients with vitiligo. Normally no treatment is required. The nevus tends to flatten and may disappear completely. The depigmented areas often persist, but may repigment after a variable period of time.

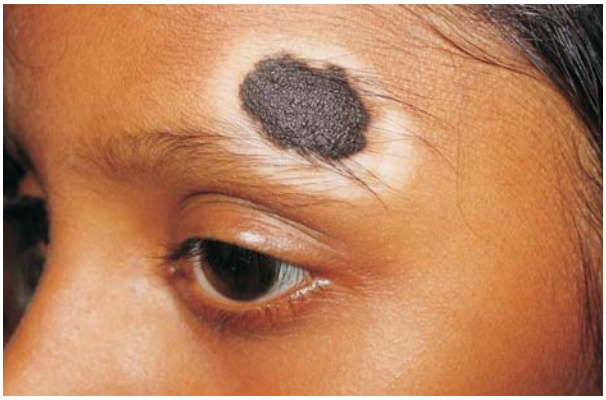

FIG. 1 *Halo of depigmentation around a central melanocytic nevus.*

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