Cutaneous Leishmaniasis

A 7-year-old girl presented for treatment of swelling over right cheek of two months duration. On examination, she had several small, painless, plaque lesions with indurated, erythematous and irregular borders and central ulcerations evident on the right cheek (***Fig* 1**). There was no neurological deficit, or lymphadenopathy in the head and neck. The medical history was not significant. Local biopsy on light microscopy showed skin with hyperkeratosis, parakeratosis and acanthosis. The dermis was filled with aggregates of large, pink, histiocytes, and mixed chronic inflammatory cells. The histiocytes contained dot-like organisms typical of LD bodies. She was treated with intramuscular sodium stibogluconate for three weeks. The lesions disappeared a month later and there has been no recurrence till the last follow-up.

Differential diagnosis of localized cutaneous leishmaniasis may include bacterial or fungal infections like impetigo, lupus vulgaris, sporotrichosis or eczema. A chronic painless ulcer, without any systemic symptoms in a child who has visited endemic region, and not responding to routine treatment should suggest possibility of cutaneous leishmaniasis.

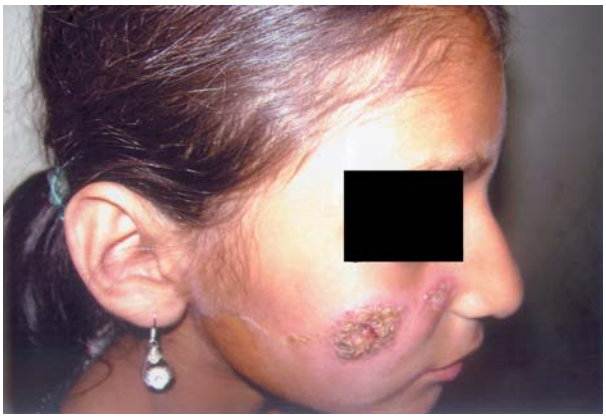

FIG.1 *Plaque lesions with indurated and irregular borders and central ulcerations.*

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Progressive symmetric Erythrokeratodermia

A 3-years-old female child presented with asymptomatic multiple well-defined erythematous scaly plaques since infancy. She was born of a non-consanguineous marriage and had uneventful prenatal and natal period. The lesions started appearing in first few months of life first on knees and then over rest of the body. The lesions were persisting in nature and she was never lesion free. However, the appearance (erythema and thickness) used to improve at times, only to get worse soon after. Rest of the history was non-contributory and no other family had similar lesions. There was no history of appearance of transient erythematous lesions. On examination, erythematous scaly plaques were present on extensor aspect of extremities (knees, lateral leg, ankle, and elbows) and sacral region with striking symmetry (***Fig*. 1**). Face,

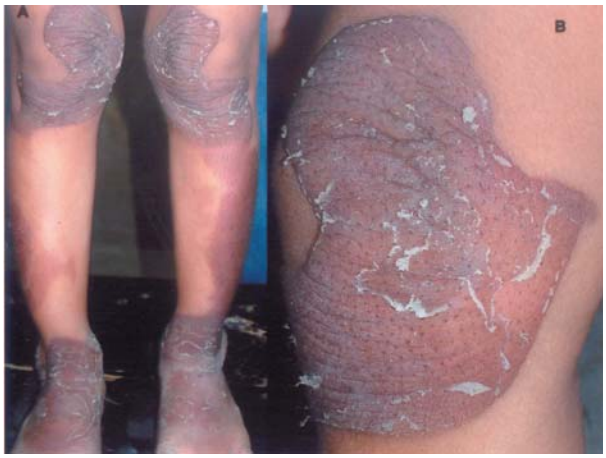

FIG. 1 *(a) Well demarcated symmetrical erythematous plaques over lower extremities. (b) Close up of a lesion.*

trunk, palm, sole, mucosa, hair, and nails were lesion free. Differential diagnoses included psoriasis, pityriasis rubra pilaris (PRP) (circumscribed type), erythrokeratodermia variabilis (EKV), and progressive symmetric erythrokerato-dermia (PSEK). Clinically, psoriasis (absence of significant scaling and negative Auspitz sign), PRP (absence of any follicular keratotic lesions) and EKV (no history of transient erythematous lesions) were ruled out. Histopathology findings were consistent with the diagnosis of PSEK. This condition is characterized by erythematous plaques that appear shortly after birth, progress slowly during the first few years, and then stabilize in early childhood. The transient migratory erythema that defines EKV is absent. It is transmitted in autosomal dominant manner and mutation in protein loricrin (envelope protein) has been found in one family. There is no specific treatment, though emollients and keratolytics provide cosmetic improvement.

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Erythema Infectiosum Rash

A 6 year old male child presented with fever with chills and rigor along with vomiting and rash over the face. On examination a erythematous rash was present on face involving cheeks and nose and sparing the lower face (***Fig.* 1**). Rash had spared the trunk and extremties and hepatosplenomegaly was also present. Clinically measles, rubella, drug reaction and some connective tissue diseases present with these features. In measles and rubella, rashes are maculopapular, spread to involve trunk and extremity including palm and soles and commonly they are associated with high grade fever. In drug reaction there is history of drug exposure and moderate to severe degree of itching is associated with rashes which are discrete. In connective tissue disorder onset of rashes is insidious, restricted to face only and often involve mucous membrane. The rashes are photosensitive and are associated with arthropathy. We made a clinical diagnosis of Erythema infectiosum. Parvovirus B19–IgM assay was positive (50 U/mL).

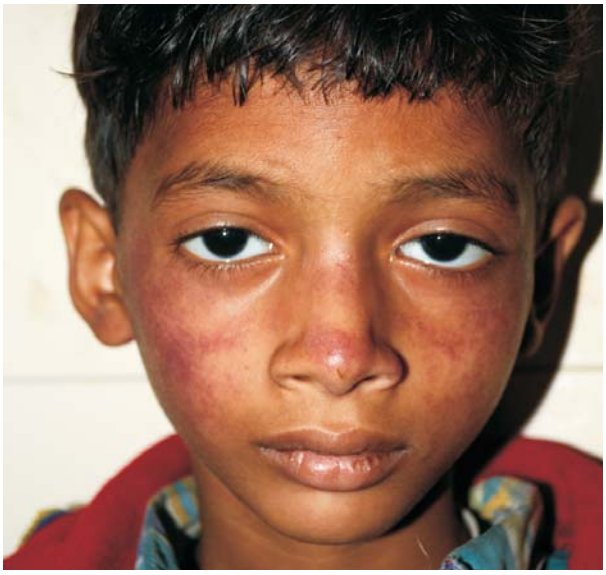

FIG. 1 *Erythema Infectiosum rash.*

Erythema infectiosum also known as Fifth disease is caused by parvovirus B19 infection. This is a benign, self limited exanthematous illness of childhood. A mild prodome is followed by the characteristic rash which occurs in three stages. It starts with erythematous facial flushing, often described as a "slapped cheek appearance". The rash spreads to involve trunk as diffuse macular erythema in second stage which is followed by central clearing of the macular lesion giving the rash a lacy reticulated appearances. Diagnosis is usually clinical but can be confirmed by B19-IgM assay in acute phase or PCR for viral DNA in immunocompromised patients. This disease is benign and there is no specific antiviral therapy.

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