Onychomadesis

A 2-year-old girl developed Hand, foot, and mouth disease (HFMD) with a self-limiting episode of fever, palmoplantar vesicular lesions and small aphthoid ulcerations of the oral mucosa. Approximately one month later, she presented with onychomadesis of all fingernails of both hands (***Figs.* 1** *and* **2**). About six weeks later, complete resolution occurred spontaneously.

Onychomadesis is a reversible, painless, non-inflammatory condition in which there is proximal shedding of the nail plate from the nail matrix. It can occur in fingernails, toenails or both. It may be secondary to systemic disorders, high fevers, bullous dermatoses, Kawasaki disease, infections (streptococcal infections and measles), zinc deficiency, local trauma, acute paronychia, and drug reactions. In addition to these causes, many cases are idiopathic. HFMD is a common pediatric viral illness that is characterized by vesicular eruptions that involve the palms, the soles, and the oral cavity. The median latency period between HFMD and onychomadesis is 40 days. The mechanism of nail matrix arrest after infection remains unclear. Transverse leukonychia and Beau lines reflects milder interruptions in ungula growth and may occur simultaneously in the same patient or a result of the same disease process.

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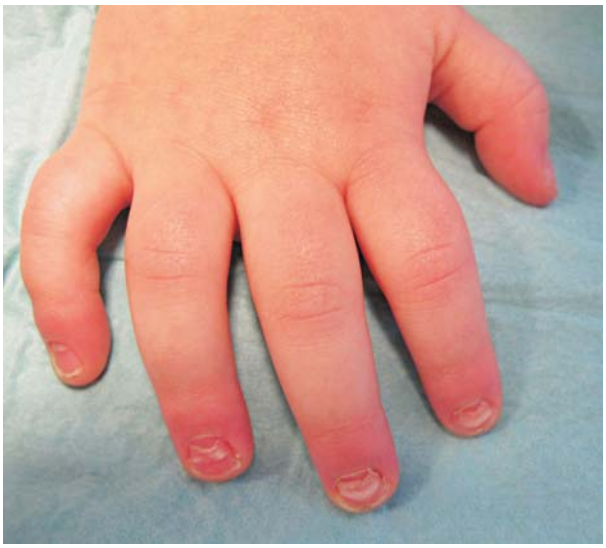

Fig. 1 *Onychomadesis of all fingernails of the right hand.*

Fig. 2 *Nail plate shedding on the first, second, third and fourth fingers of the left hand.*

Acute Hemorrhagic Edema of Infancy

A 14-month-old girl presented with acute onset erythematous skin eruption on her body, following an episode of upper respiratory tract infection. On examination, the child was febrile and the vitals were stable. There were multiple, non-tender, purpuric targetoid lesions studded with vesicles on her face, pinna, extremities and buttocks. The mucosa and the trunk were spared. There was mild non-pitting edema over the upper extremities and the face. Systemic examination was normal. Routine blood examination, coagulation profile, renal function tests, blood culture, and urine analysis were normal, except for mild leucocytosis (total leukocyte count 12,600 mm^3). Histopathlogical examination from the lesion showed features of leucocytoclastic vasculitis. A diagnosis of Acute hemorrhagic oedema of infancy (AHEI) was made. Fever subsided in two days and the skin lesions completely subsided within the next two weeks.

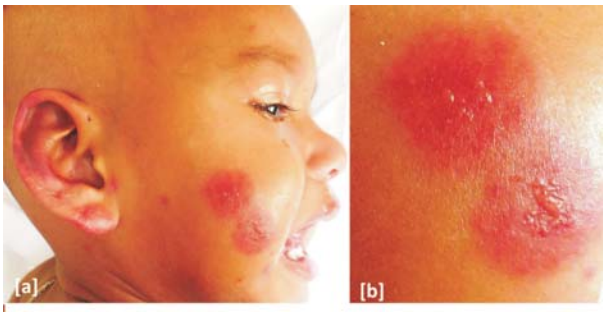

FIG. 1 (*a*) *Purpuric targetoid lesions on face; (b) Close-up view of the lesion.*

AHEI is a benign, self-limiting leucocytoclastic vasculitis generally affecting children under the age of 2 years. An upper repiratory illness usually precedes the sudden onset of red macules or urticarial skin lesions. AHEI lesions vary from 0.5 to 4 cm in size occasionally becoming confluent to annular or targetoid purpuric lesions. It mainly affects the face and extremities, sparing the trunk, and often accompanied by non-pitting edema.

Differential diagnosis of AHEI include Henoch Schonlein purpura (older age, smaller lesions, facial sparing, systemic involvement, slow resolution, meningococcemia (central necrosis), erythema multiform (three concentric color zones), Sweet's syndrome (erythematous blue or violet papules, plaques, or nodules often with a pseudo-vesicular appearance), urticarial vasculitis (absence of target-like lesions; purpuric spots visible on diascopy, hyperpigmentation on healing), and fixed drug eruptions (round or oval sharply delineated erythematous plaques with central blister or necrotic area).

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X-linked Ichthyosis

A 9-year-old boy presented with black scales all over the body sparing the flexures. There was a history of consanguineous parentage and prolonged labor. Scaling started from three weeks of age with exacerbations in the winter and remission in summer. On examination, there was coarse hyper pigmented scaling over the whole body (***Fig.* 1**) with sparing of flexures. Right sided cryptorchidism was present till the age of four years. Ophthalmological examination, blood counts, chest *X*-ray and urine examination were normal. Patient was diagnosed as X-linked ichthyosis based on clinical features, history of prolonged labor and cryptorchidism. He was prescribed emollients and 10% urea; he showed improvement in scaling after four weeks.

X-linked ichthyosis is considered one of the five main types of ichthyosis. The others being; Ichthyosis vulgaris (no affection of posterior neck and back of ears, no history of prolonged labour or cryptorchidism), Lamellar Ichthyosis (scales are larger and darker in size with affection of the flexural surface), Congenital non-bullous ichthyosiform erythroderma and Epidermolytic Hyperkeratosis.

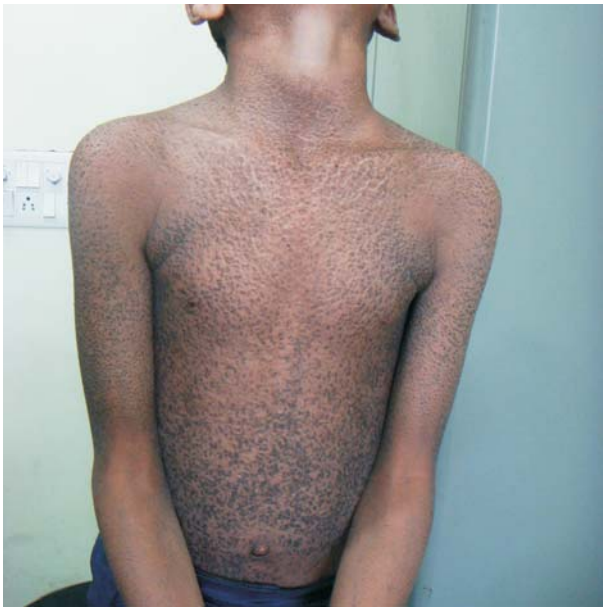

FIG. 1 *Generalised dark scaling over trunk with sparing of flexures.*

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