Bart Syndrome

A 27-day-old neonate, product of 3rd degree consanguineous marriage, youngest of three siblings, presented with complaints of absence of skin of medial aspect of both legs and nail dystrophy, and fluid-filled lesions on trauma-prone sites of body since 2nd day of life. Examination revealed absence of skin involving anteromedial aspect of shin and dorsum of both feet (***Fig.* 1**). Nails were dystrophic. Multiple erosions involving buttocks, elbows and occipital scalp were noted. Mucous membranes were normal. Histopathological examination of cutaneous blister revealed subepidermal blister and absence of inflammatory infiltrate on histopathology and immune complex on direct immunofluorescence. A diagnosis of Bart syndrome with underlying Junctional or Dystrophic epidermolysis bullosa was made. Erosions were covered with paraffin gauze dressing, thin layer of mupirocin and non-adherent dressing. Parents were counseled about the favourable outcome of the disease.

Bart syndrome is rare disorder characterized by triad of congenital localized absence of skin (CLAS), mucocutaneous blistering and nail abnormalities. CLAS is classically present as S-shaped area from knee to anterolateral surface of leg, ankle and foot, and is generally bilateral. Cause of CLAS has been proposed to be rubbing of limbs together *in utero*. It may represent any of the three subtypes of epidermolysis bullosa: simplex, junctional or dystrophic. Diagnosis is confirmed by histopathological studies, antigen mapping and genetic studies. Prognosis is favourable in absence of other anomalies as localised absence of skin heals with minimal scarring and blistering improves with time.

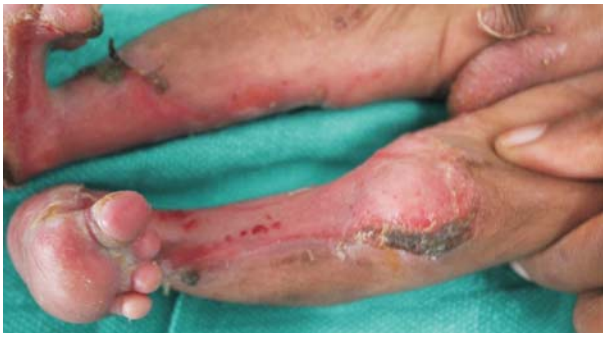

FIG.1 *Absence of skin over anteromedial aspect of shin and dorsum of both feet in Bart syndrome.*

SHEKHAR NEEMA[1], SWETA MUKHERJEE[2] AND SUBHASH CHANDRA SHAW[3]
*Departments of [1]Dermatology and [3]Pediatrics, Armed Forces Medical College; and [2]Department of Pediatrics, Command Hospital; Pune, Maharashtra, India; *drscshaw@rediffmail.com*

Lip Smacker's Cheilitis

A 10-year-old girl presented with mildly pruritic scaly rash around the lips for the past one month. She denied the use of any lipstick, dentrifices or mouthwashes. On examination, there was a well-demarcated erythematous plaque with scaling and fissuring, symmetrically lining the perioral skin and vermilion margin of both lips (***Fig.* 1**). Rest of the mucocutaneous and systemic examination was unremarkable. On further enquiry, her mother recalled her ward's recent habit of constantly licking the lips with the tongue. A diagnosis of lip smacker's cheilitis was made; topical fluticasone cream and petrolatum jelly was prescribed.

Lip smacker's cheilitis is characterized by persistent lip-licking, causing chronic inflammation of the vermilion borders with clearly demarcated perioral erythema. Cheilitis may also occur secondary to atopic dermatitis (presence of atopic stigmata), psoriasis (scaly, erythematous plaque which elicits Grattage test and Auspitz sign), long-term actinic exposure (lower lip affected commonly), drugs (retinoids), and allergic contact (toothpaste, lipstick). Behavioral therapy and topical tacrolimus, pimecrolimus cream, or low-potent corticosteroid preparations are usually helpful.

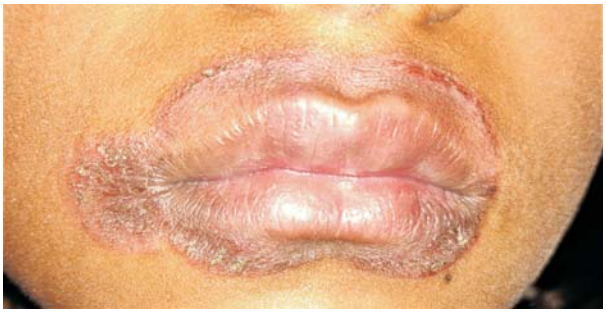

FIG. 1 *Perioral erythema with scale-crusts and fissures.*

ABHEEK SIL[1] AND PALLAVI PRIYAM[2]
Departments of [1]Dermatology, Venereology and Leprosy and [2]Psychiatry, RG Kar Medical College, Kolkata, West Bengal, India.
[1]abheek.sil@gmail.com