

Febrile Rash and Convalescent Rash of Dengue Fever

A 1-year-old boy infant presented with fever for 3 days. On examination he was febrile and his face, trunk and extremities were erythematous which blanched upon pressure (**Fig. 1**). His platelet count dropped to 83,000 per μL on day 5 of illness. His dengue serology IgM was positive suggestive of primary dengue infection.

A 9-year-old girl presented with fever for 4 days. On day 8 of illness, when her fever subsided, she developed hypotension. Her platelet count dropped to 15000/ml and hematocrit increased to 42.8%. She was resuscitated with fluid boluses. She developed typical dengue rash of convalescence 3 days after defervescence (**Fig. 2**). Her dengue serology IgM and IgG were positive, suggestive of secondary dengue infection.

During the first 24-48 hours of fever, children with dengue fever may develop a transient generalized macular erythematous rash which blanches upon pressure. The convalescent rash of dengue fever appears about 2-3 days after defervescence. It is characterized by generalized confluent petechial rash which does not blanch upon pressure, with multiple small round islets of normal skin. It is otherwise called “white islands in a sea of red”. Some children with this rash may experience generalized pruritus. This rash gradually fades over one week.

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FIG. 1 Febrile rash of dengue which blanches upon pressure.



FIG. 2 Convalescent rash of dengue – “White isles in the sea of red”.

Darier-White Disease

A 6-years-old boy presented with multiple dark, raised lesions all over the body since 1 year (**Fig. 1a**). The disease began with discrete hyperpigmented hyperkeratotic papules over the knee and elbows which later progressed to involve the preauricular region, ear lobe, neck, both flexor and extensor aspect of upper limbs and lower limbs and buttocks (**Fig. 1b**). There was history of photo-

exacerbation of the lesions. The child complained of pruritus and difficulty in sitting due to pain because of multiple hyperkeratotic lesions over the buttocks. There was presence of palmar pits. Oral mucosa and nails were normal. His 4-year-old sibling also presented with similar lesions over the knees and elbows. A clinical diagnosis of Darier-White disease was made. Histopathological examination from punch biopsy of a lesion showed acantholysis along with classical dyskeratosis and hyperkeratosis in the epidermis.

Darier-White disease or keratosis follicularis is said to occur as a result of mutation in the *ATP2A2* gene located on chromosome 12q23-24.1, responsible for coding sarco/endoplasmic reticulum calcium ATPase type 2 (SERCA2). It is characterized clinically by hyperkeratotic papules distributed mostly on the seborrheic areas of the body. Nail involvement is characterized by V-shaped nicking at the distal aspect of the nail bed, longitudinal red and white alternating bands, and subungual hyperkeratosis. Mucosal membrane involvement may occur as white papules on the buccal mucosae, palate, and gingiva with a cobblestone appearance. Palmoplantar involvement usually presents as discrete, punctate keratoses that appear as small, hyperkeratotic papules or small, centrally depressed pits. In flexures like axilla and groin, the lesions may become large exuberant growth. They may get infected due to constant maceration resulting in malodorous purulent discharge. Heat, sweat, humidity, sunlight, oral corticosteroids and mechanical trauma have been reported to exacerbate this condition.

Conventional therapy for severe disease still relies greatly on oral retinoids. Acitretin is effective at 0.6 mg/kg/day, the hyperkeratosis is reduced and papules are flattened. Basic measures include use of sunscreens, cool cotton clothing, and avoidance of hot environment. Moisturizers with urea or lactic acid can reduce scaling and hyperkeratosis. Surgical treatment includes dermabrasion, carbon dioxide laser, and the erbium YAG laser. The condition runs a chronic relapsing course, with exacerbations throughout life.

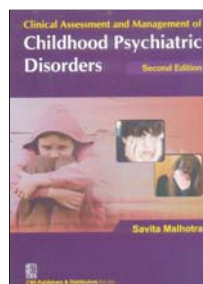


(a) (b)
FIG. 1 Multiple hyperkeratotic lesions including (a) knees and elbows, and (b) buttocks.

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BOOK REVIEW



**Clinical Assessment and
 Management of Childhood
 Psychiatric Disorders**

SAVITA MALHOTRA
*CBS Publishers & Distributors; New
 Delhi.*

Pages: 226; Price: Rs. 350/-

This edition contains 12 chapters and a glossary of terms, Child Guidance Clinic Proforma and important assessment scales (many by the author) adapted for India. The development perspective of the child has been provided with an emphasis on the roles of family and school. The approach to psychological, psychiatric and neurodevelopment assessment is elucidated in detail. The

International classifications of childhood psychiatric disorders is also given. The important issues related to adolescence are discussed separately. The book provides steps to diagnose and treat common childhood psychiatric emergencies. The simple presentation style of the book makes it useful for undergraduate and postgraduate students, pediatricians and mental health professionals. Inclusion of case reports, photographs, and childhood problems related to schools in future edition will enrich the text and make it also useful for teachers and parents.

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