Acute Generalized Exanthematous Pustulosis

A 12-year-old boy presented with fever and generalized rash, starting 48 hours after administration of amoxicillin tablet for lower respiratory tract infection. Cutaneous examination showed generalized erythematous rash, surmounted by numerous non-follicular tiny pustules, with accentuation over the flexural areas (***Fig.* 1**). The pustules had ruptured in multiple areas with desquamation. Histology showed subcorneal spongiform pustules, keratinocyte necrosis, perivascular inflammatory infiltrate rich in neutrophils and eosinophils, and focal areas of leukocytoclastic vasculitis. We made a diagnosis of acute generalized exanthematous pustulosis due to amoxicillin, and the drug was immediately stopped. We prescribed emollients and antihistamines, leading to clearance with exfoliation; patient was well after 12 days.

This condition is characterized by sudden onset of erythematous and edematous eruptions of numerous sterile non-follicular pustules. The lesions start on face or flexures, rapidly disseminate and resolve spontaneously with exfoliation. Common precipitating drugs include ampicillin, amoxicillin, macrolides, quinolones and sulfonamides. The differential diagnoses are generalized pustular psoriasis (presence of psoriatic lesion elsewhere, recurrent, less flexural, drug history absent, eosinophils and dermal edema absent), disseminated candidiasis (background of immunosuppression), and staphylococcal scalded skin syndrome (fever, skin tenderness, generalized erythema and Niklosky sign positive).

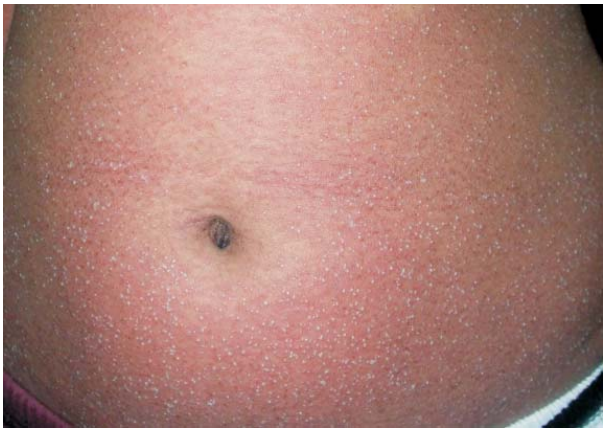

FIG. 1 *Generalized erythematous rash surmounted by non-follicular tiny pustules.*

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Calcinosis Cutis

A 10-year-old boy presented with fever, weakness, joint- pain and difficulty in limbs movement for last four years. On examination, he had a proximal muscular weakness (LL>UL), periorbital pinkish discoloration papular lesions on knuckles and elbow, and discharging whitish deposit at both knee joints (***Fig.* 1**). Investigations revealed anemia (hemoglobin 8.4 gm/dL), transaminitis, C-reactive protein (72 mg/L), erythrocyte sedimentation rate (104 mm FHR), creatinine phosphokinase (1012 U/L), and positive antinuclear antibody (ANA) test. A diagnosis of juvenile dermatomyositis with calcinosis cutis was considered. We administered methylprednisolone pulse therapy for 3 days, followed by oral steroid, which led to marked symptomatic improvement.

Calcinosis cutis is a pathological condition of abnormal deposition of calcium in the skin and subcutaneous tissue. It is classified into dystrophic, metastatic, idiopathic, iatrogenic and calciphylaxis groups. Dystrophic is the most common type and usually associated with connective tissue disorders.

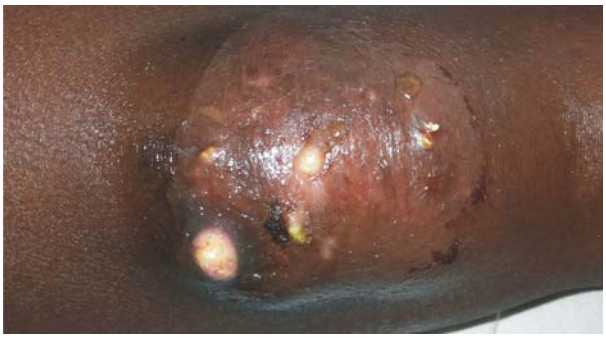

Fig. 1 *Whitish lesions with deposits and discharge in the region of left knee joint.*

It is frequently distributed at elbows and knees joints, and can lead to pain, chronic ulceration, and secondary infection. Treatment includes calcium channel blockers, colchicine, minocycline, warfarin, aluminum hydroxide, bisphosphonates and probenecid.

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