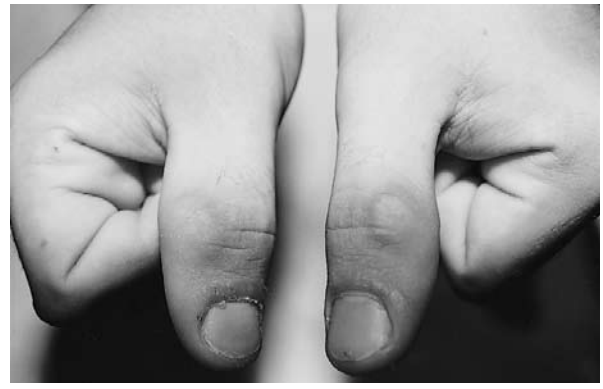
Callosities due to repeated friction.



Dear Editor,

the case here reported is a peculiar case, which can be useful from a teaching point of view. M.B. was a 15-year-old boy with two raised, symmetrical lesions on the thumbs. The lesions were oval, skin colored, elastic at palpation, not itchy and not painful. The lesions appeared about one month ago. As the lesions were not reminiscent of any well-known disorder, I went into the clinical history thoroughly. Recently, the boy had a scooter as a present and immediately became very fond of it, persevering on the grips of the handlebart. The lesions were really in the exact point of contact with the grips in "acceleration position". This is why I believe that we are dealing with callosities due to constant and repeated friction, deteriorated by juvenile passion. I called this disorder "motor biker's thumbs". Is there an alternative to this diagnosis?

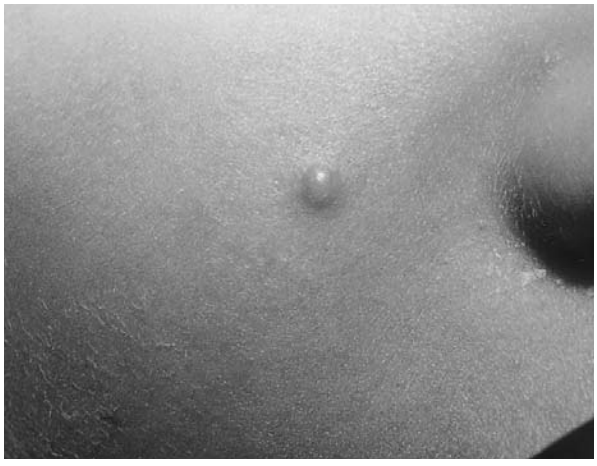
Giorgio Rovatti
Pediatrician - Modena (Italy)

Dear dr. Rovatti,

I agree with your diagnosis of callosities due to repeated friction. If you verified that really there is a friction with the handlebart of the motor, there is no alternative to your diagnosis.

Ernesto Bonifazi

Unusual lesion...



Dear editor,

what is your diagnosis for this papule, which appeared about four months ago on the cheek of Enrico, a two and half years old boy?

The lesion slowly grew in the first two months till the actual size. It consists of a yellowish papule, surrounded by a yet visible erythematous halo and crossed by fine telangiectases. At palpation, its surface is smooth and its consistency soft and elastic. The lesion is not painful.

I ruled out many diagnoses because no one fully convinced me. Juvenile xanthogranuloma usually appears earlier, pilomatricoma is harder

and deeper, molluscum contagiosum is whitish with a central umbilication, milium is more white and smaller. Sincerely yours

Giorgio Rovatti
Pediatrician - Modena (Italy)

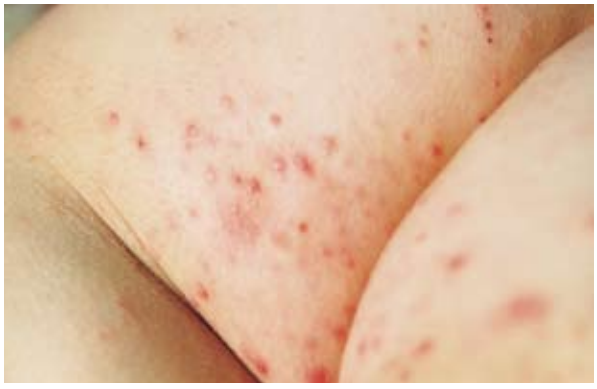
Dear dr. Rovatti,

the lesions is unusual at that age. I am impressed by its cystic appearance, reminiscent of a liquid content. It is likely a benign tumor of gland type.

I think that a wait and see policy is the best for Enrico. The tumor is so superficial that could be transepidermally eliminated. If this does not happen within February-March, the tumor could be removed by excision under local anesthesia.

Ernesto Bonifazi

Folliculitis of the buttock.



Dear editor,

here enclosed please find some photographs of a little girl, Vanessa V., aged 6 years. In July '98 she presented the first episode, which is illustrated in the photograph. I diagnosed infectious folliculitis and prescribed an antibiotic treatment with macrolides per mouth for a period of 8 days. The treatment resulted in a slight improvement of the lesions, which relapsed within a few days. In the second decade of August, Vanessa was visited by a dermatologist, who prescribed a different antibiotic treatment, without obtaining better results. Since then, new episodes occurred separated by periods without lesions. Now, the lesions are almost always present. The little girl was visited by several dermatologists, due to the justified fear of the mother. However, we are not able to overcome the problem. Sincerely yours

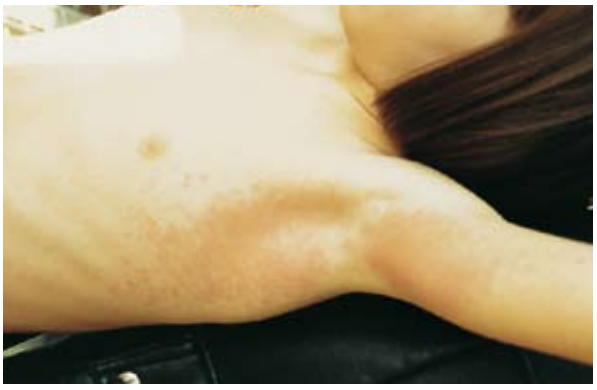
Vitalia Murgia
Pediatrician - Treviso (Italy)

Dear Dr. Murgia,

the last time I talked about "Folliculitis of the buttock" was in the issue 2/98 of the Book of Practical Pediatric Dermatology, on page 336. I use this term for non infectious folliculitis, prevailing on the buttocks. There is no evidence of abnormalities of chemotaxis, killing or phagocytosis. Sweating, physical activity with synthetic, close-fitting clothes such as cyclist trousers and constitutional factors play a significant role. This is why family history should be investigated with the aim of finding similar problems in relatives. Frequent bathing with antiseptic soaps should be advised. Avoiding sweating and close-fitting synthetic clothes is also useful. Sincerely yours

Ernesto Bonifazi

A.P.E.C.



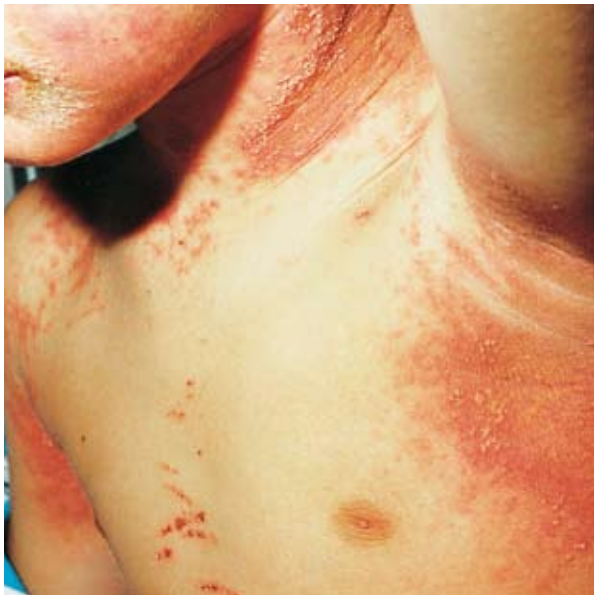
I send you the first case of APEC observed in my region.

C. Giovanna, a 7-year-old girl, presented pharyngeal inflammation with modest temperature for a couple of days, without significant pharyngalgia, neither enlargement of the latero-cervical lymph nodes. Two days after the disappearance of the above mentioned symptoms and signs a macular and papular rash with small, 2-4 mm in diameter lesions, appeared on the left axillary fold and extended on the left hemithorax and proximal part of the arm. She reported moderate itching. In the following two days the left popliteal fold, neck and flexor aspect of the forearm were also affected. On the other hand, the rest of the skin, particularly on the controlateral side, was not affected. Giovanna had been unsuccessfully treated for 15 days with antihistamines, when she was visited for the first time. There was not fever neither enlargement of the lymph nodes. There were no other symptoms and signs, besides a modest pruritus. The clinical features, particularly the asymmetry of the lesions, led to the diagnosis of APEC.

Sincerely yours

Piero Polcino
A.O. "G. Rummo", Divisione di Pediatria
Benevento

Acute self-healing pustulosis.



Dear editor,

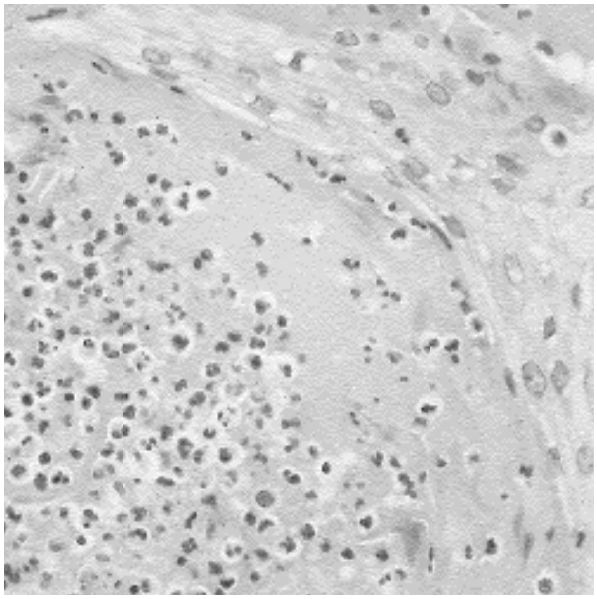
here is reported a case of short-living, self-healing acute pustulosis. C.M. was born in 1990.

The family history was characterized by an atopic mother, who was sensitized to pollens, included grass pollens, and hair cat. The personal history put in evidence enuresis, febrile seizures at the age of 1 year and half and recurrent infections of the upper respiratory tract.

On October, 18, 1996, a persistent cough with pharingo-tonsillitis in plaques and fever (37.5° C) led his general practitioner to prescribe amoxicillin per mouth at a dosage of 500 mg per day and betametasone with associated chlorphenamine per aerosol. This treatment led to a moderate initial improvement. On October, 11, 1996, due to a modest bronchospasm, loratadine 10 mg per

day was prescribed. On October, 2l, 1996 the little patient was referred to the First Aid, due to a pustular rash on erythematous and edematous skin. The rash was initially localized on the perioral region and on the neck and associated with eyelid edema. Due to these signs the boy was hospitalized in the Department of Pediatrics. The rash progressively extended to the upper trunk, the axillary and inguinal folds and to the foreskin, leading the pediatricians to ask for a dermatological visit. The dermatological examination, which was performed on October, 25,1996 showed eyelid edema and erythematous and edematous, roundish lesions, covered by small, 1-2 mm in size, non follicular pustules. The lesions were localized on the face, ears, neck, upper trunk, axillary (Fig. 1) and inguinal folds. There were also erythematous and eroded lesions on the foreskin. Fever > 38°C was present. The boy was affected by intense itching. There was no personal or family history of psoriasis. Moreover, the patiend had no contact with mercurials.

The laboratory examinations showed leukocytosis (12,800) with neutrophilia (9,216/ml) and A.S.L.O. 778 UI/ml. The other routine laboratory examinations were within normal limits, whereas no evidence of mercury was found in the urine. No serum antibodies against enterovirus, adenovirus, coxsakie, A, B and C hepatitis virus, cytomegalovirus, Epstein-Barr virus and mycoplasma pneumoniae were detected at the moment of hospitalization neither two weeks later. The cultures from pharyngeal exudate and cutaneous pustular lesions did not grow any pathogenic bacteria.



The patient underwent a skin biopsy. On light microscopy, a slight, basket-like, ortokeratotic hyperkeratosis was associated to a modest acanthosis. There were also subcorneal pustules in various evolution phase. In the papillary dermis there were dilated capillaries and a perivascular and interstitial infiltrate, mainly consisting of eosinophils, which was reminiscent of leukocytoclastic vasculitis. The pustules were filled in with polymorphonuclear leukocytes, cell residua and, occasionally, dyskeratotic cells. Finally, the prickly layer showed moderate intra- and extracellular spongiosis.

After withdrawing the antibiotic treatment, systemic and topical antiinflammatory corticosteroids were administered. The pustular eruption lasted for 10 days and was followed by a slow resolution of the lesions with large scales. Two years later the patient did not show any symptom or sign of cutaneous disorders.

In our opinion this is a pediatric case of Exanthematous Acute Generalized Pustulosis. This cutaneous disorder affects subjects without history of psoriasis. It is characterized by a sudden, febrile onset, which is associated with an eruption of small, steriles, non follicular pustules, arising on erythematous skin. The eruption regresses spontaneously in about 10 days. Neutrophilic leukocytosis is often associated. On light microscopy, spongiform subcorneal or intradermal pustules are associated to papillary edema with polymorphic inflammatory infiltrate and, sometimes, leukocytoclasic vasculitis and keratinocyte necrosis. The causal factors of this disorder are mainly iatrogenic, although in some cases acute virus infections, hypersensitivity to mercury or its derivatives and ultraviolet radiations are shown. However, in 5% of cases no causal factors can be detected. The relationship of this disorder with psoriasis is debated. The causal factor of our case could be the intake of amoxicillin.

Betto P., Gennari E., Vassilopoulou A.
Dept. of Dermatology - Azienda Ospedaliera of Vicenza (Italy)

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Dear colleagues,

your case is reminiscent for me of a child, Giuseppe D., I followed for more then 15 years until now. First time, I observed Giuseppe when he was a few months old, with a febrile pustular eruption, which was similar in its clinical features and evolution to your reported case. Till the age of ten, Giuseppe presented other three similar episodes, sometimes with large, scarlet-like scales in the palmar and plantar region. Since the age of ten Giuseppe presented more frequent episodes leading to the final diagnosis of febrile generalized pustular psoriasis.

In my opinion some cases reported in the relevant literature are from the onset pustular psoriasis or turn later into a true form of pustular psoriasis. As in the case of Giuseppe, maybe you have to wait for more than two years to observe the evolution towards a true pustular psoriasis. You believe that your case is attributable to amoxicillin, without giving any support in favor of this diagnosis. I do not believe that an intradermal test with cilligen or amoxicillin is harmful. Unfortunately, a positive result with such test could be hardly related with this disorder. The only test able to confirm the responsibility of amoxicillin for this pustular eruption, even though it is not able to clarify the pathogenetic mechanism, is an oral challenge test. Whether this test is ethically correct and practically useful for the child can be discussed.

Ernesto Bonifazi