Eruptive Lingual Papillitis

An 8-year-old boy presented with painful erythematous papules over tongue and excessive salivation for 3 days. On examination, tongue was studded with multiple erythematous tender papules and few vesicles (**Fig. 1**) Submental and submandibular nodes were enlarged and non-tender. The lesions resolved completely after 10 days. The condition was diagnosed as Eruptive lingual papillitis (ELP) based on typical presentation – acute onset, painful lesions on tongue only (no other mucosal or skin lesions) and excessive salivation.

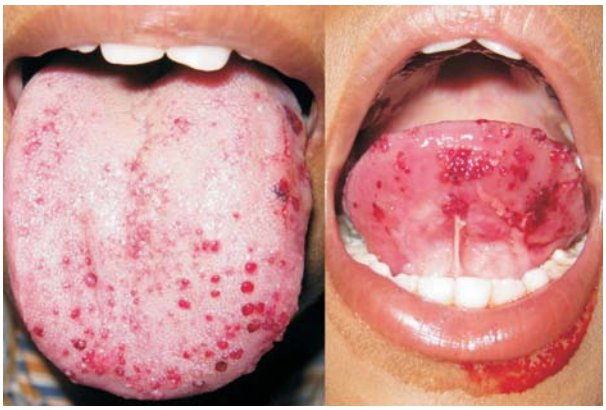

FIG. 1 *Multiple erythematous papules and few vesicles over tongue. Excessive salivation can be appreciated.*

ELP is an acute self-limiting condition, probably of viral origin, involving the fungiform papillae of tongue of children. Fever, difficulty in feeding, salivation and cervical adenopathy are usually associated. Spontaneous involution is seen in 2-15 days but may recur. Differential diagnoses are Strawberry tongue of scarlet fever (widespread erythema and minute papules on skin), hand-foot-mouth disease (vesicles on palms and soles), and food allergy. There is no specific treatment apart from. maintaining oral hygiene.

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Bullous Impetigo

A 5-year-old girl presented to us with complaints of exudative painful lesions on the face and upper back for 6 days. The lesions started as multiple fluid filled lesions on the face which turned turbid, ruptured, spread and involved the back. On examination, multiple pustules with level of pus (positive hypopyon sign) were seen in few lesions; erosions and honey coloured crusts were noted on the upper back (***Fig.* 1**) and face. Culture of pus showed the growth of *Styphylococcus aureus*. She was treated with a 7 day course of antibiotics following which lesions cleared.

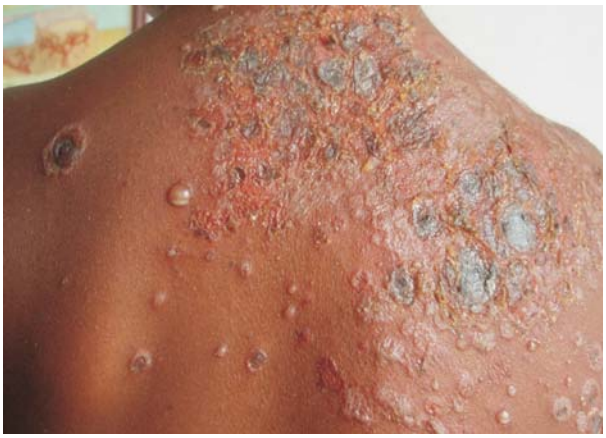

FIG. 1 *Crusted lesions with bullae the arrow showing level of pus (Hypopyon sign).*

The lesions of bullous impetigo are commonly seen on the face, trunk and extremeties which are vesicles to begin with and later becoming pus filled, followed by rupture and crusting. When the patient is in the erect position, the pus that is heavier settles down giving a positive hypopyon sign. Bullous impetigo has to be differentiated from bullous erythema multiforme (typical targetoid lesions), bullous lupus erythematosis (systemic involvement), bullous pemphigoid (rare in childhood), and subcorneal pustular dermatosis (sterile and classically involves intertriginous areas).

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