

Nicolau's Syndrome

An 11-year-old girl, suffering from Dengue fever, developed pain and swelling in the dorsum of left hand following intravenous Ceftriaxone. The swelling resolved over 8 days and the affected area turned reddish violet and eventually black over next 20 days. On cutaneous examination, a single necrotic eschar 5×7 cm with a surrounding tough, fibrotic margin was present on the dorsum of the left hand (**Fig. 1**). On the basis of history and clinical features, we diagnosed Nicolau's Syndrome. Debridement of the area of necrosis was done along with oral antibiotics. Her wound healed in three weeks (**Fig. 2**).

Nicolau's Syndrome – also known as Embolia Cutis Medicamentosa – is a rare, cutaneous, adverse complication of drug administration. Inflammation, embolism, thrombosis and vasospasm are the various mechanisms proposed. Direct or indirect vessel damage involving any or all these mechanisms ultimately leads to peripheral arterial occlusion. Differentials to be considered are acute compartment syndrome (severe pain, pallor, swelling, paresthesia and poikilothermia), subcutaneous fat necrosis (seen exclusively in newborns), and gangrene (distally located). Prevention is by taking care to avoid accidental intra-arterial or para-arterial injection or injection of the drug into an arteriole. Debridement is the mainstay of therapy.



FIG. 1 Necrotic eschar on dorsum of left hand.



FIG. 2 Healed lesions after 3 weeks.

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Erythema Annulare Centrifugum

An 11-year-old boy presented with recurrent, self-healing, asymptomatic eruptions involving trunk, over the last three years. The eruptions used to start as small red papules, progressing centrifugally to form annular plaques with a central clearing. No systemic features or mucosal lesions were present. Physical examination revealed multiple erythematous annular and polycyclic plaques, with trailing scaling at their inner margins (**Fig. 1**). The lesions were present exclusively on trunk; rest of the muco-cutaneous examination was non-contributory. There was no lymphadenopathy. KOH mount of scales did not reveal any fungal hyphae. Blood investigations were non-contributory. Histopathology from the erythematous margin showed mild hyperkeratosis, focal parakeratosis, and perivascular lymphocytic infiltrate in the superficial as well as deep dermis. The patient was diagnosed with erythema annulare centrifugum (EAC).

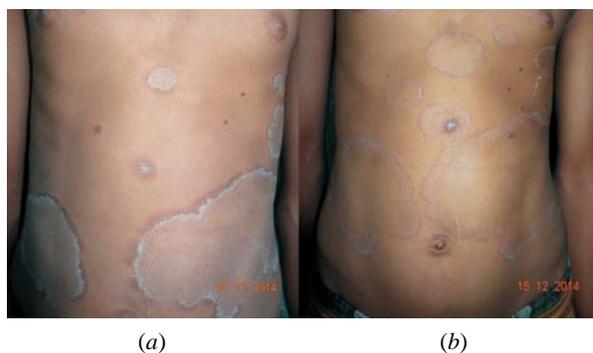


FIG. 1 Annular erythematous plaques with trailing scales on trunk; on presentation (a), and after 2 weeks (b).

EAC is one of the figurate or gyrate erythemas, others being erythema marginatum (transiently seen in acute rheumatic fever), erythema migrans (rash of localized Lyme disease caused by *Borrelia burgdorferi*) and erythema gyratum repens (usually associated with visceral malignancy, pulmonary tuberculosis, lupus erythematosus and azathioprine). EAC presents as asymptomatic annular,