Lichen Nitidus

A 1 month-old baby presented with whitish pinhead sized papular lesions below the lower lip for 7 days. The baby had no other complaints. On examination it was found to be a case of lichen nitidus (***Fig.* 1**). Lichen nitidus is a common, benign skin condition. It consists of small, white to skin colored papules on the skin that tends to appear in clusters. It can be seen in any age group but mostly affects children. It is a usually self limiting with no complications. It needs to be differentiated from milia, lichen scrofulosorum and keratatosis pilaris. A biopsy usually clarifies the diagnosis.

It usually appears on trunk, legs and forearms but may also be seen on palms, soles and rarely on the face as was the case with this patient. Apart from occasional itching it does not cause any other problem but may give rise to cosmetic problems. Therapy may be given because of cosmetic reasons in the form of topical steroids (fluorinated group of steroids), antihistaminics and topical retinoids. Oral prednisolone and methylprednisolone have been used in generalized disease.

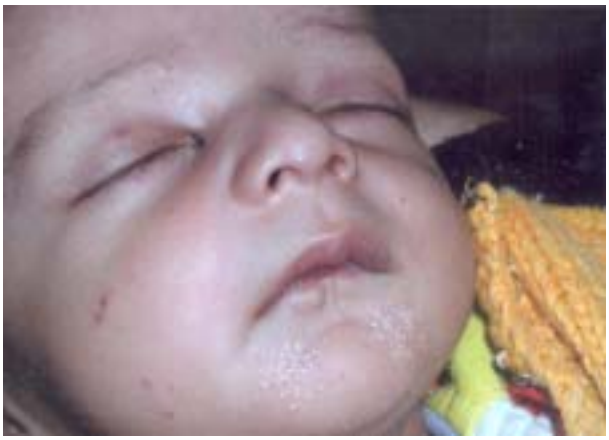

FIG. 1 *Lichen nitidus lesions over chin.*

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Generalized Pustulosis

An 11 year-old boy presented with generalized skin rash and fever of two days duration following intake of cefadroxil for the treatment of a boil, 24 hours prior to the eruption. Examination revealed superficial, tiny, non-follicular pustules on an erythematous background particularly involving the abdomen, chest, neck, upper limbs (***Fig.* 1**), back, and buttocks (***Fig.* 2**). The scalp, palms, soles, nails, and mucosae were uninvolved. Systemic examination was unremarkable apart from mild fever. Gram staining and culture of pus taken from the lesions were noncontributory. Histopathology showed spongiosis, sub-corneal pustules, perivascular polymorphonuclear infiltrate, and dermal edema. Investigation revealed polymorphonuclear leucocytosis ($8x10^9$/L) and normal eosinophil count. Other routine laboratory investigations were normal. A patch test reaction with cefadroxil was positive.

The diseases considered in the differential diagnoses in this child were impetigo, pustular psoriasis, drug reaction with eosinophilia and

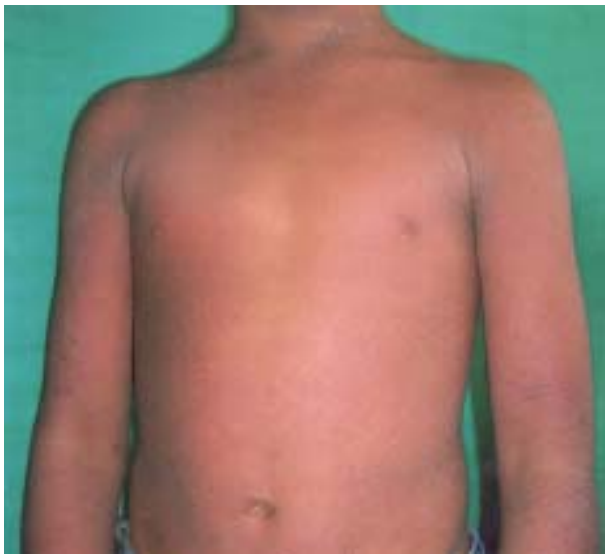

FIG.1 *Superficial tiny non-follicular pustules on an erythematous background on abdomen, chest, neck, and upper limbs.*

systemic symptoms (DRESS), subcorneal pustular dermatosis (SCPD) and acute generalized exanthematous pustulosis (AGEP). The gram staining and bacterial culture were negative thus excluding the diagnosis of impetigo. Absence of any previous history of psoriasis, rapid onset and resolution and histopathologically presence of spongiosis and papillary dermal edema ruled out pustular psoriasis. DRESS was excluded owing to the absence of systemic involvement and eosinophilia. Lack of characteristic lesion with circinate spreading outline and temporal course of the disease with rapid resolution ruled out the diagnosis of SCPD.

Our patient fulfilled all the criteria for the diagnosis of AGEP, which are: the presence of numerous, small (<5mm), non-follicular pustules arising on widespread edematous erythema, pathology revealing intra-epidermal or sub-corneal pustules, fever (>38ºC), blood neutrophilia (neutrophil count >7x10^9/L) and acute progression with spontaneous recovery within 15 days. Cefadroxil was stopped and the child was treated with topical fluticasone propionate cream resulting in complete healing within two weeks.

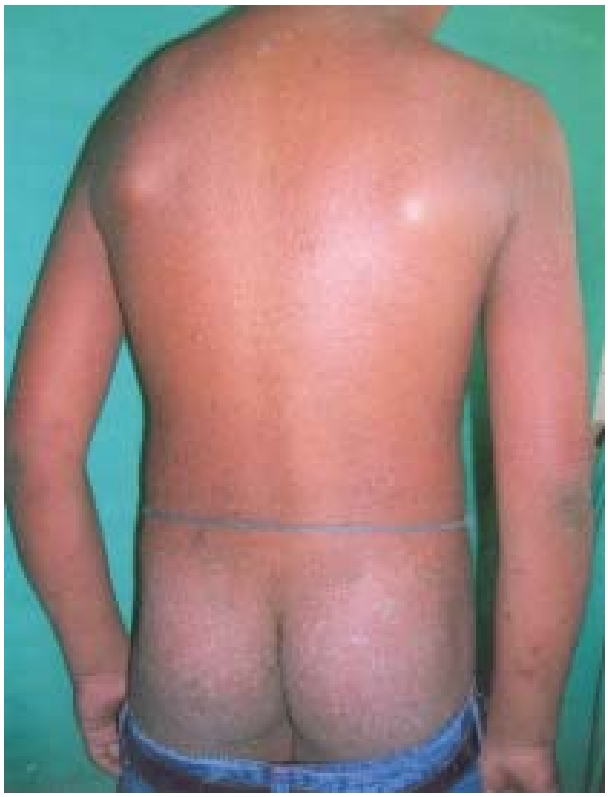

FIG.2 *Diffuse non-follicular pustular lesions on an erythematous background.*

AGEP is a rare self-limiting cutaneous reaction pattern induced mostly by systemic drugs and can affect any age group. Most common drugs implicated in the causation of AGEP are antibacterials (particularly betalactams and macrolides), anticonvulsants, and anti-inflammatory drugs. Infection with cytomegalovirus, human parvovirus B19 and Epstein Barr virus, as well as brown recluse spider bites, can rarefy incite AGEP.

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