Erythema Toxicum Neonatorum

A 4-day-old male baby, born after uneventful gestation and vaginal delivery, was brought for evaluation of cutaneous lesions. The parents had observed blotchy redness over the face few hours after birth. On examination, the baby was comfortable, afebrile with no lymphadenopathy. Cutaneous lesions comprised numerous, discrete, blotchy erythematous macules with a central vesicle or pustule involving face, trunk and limbs, distributed predominately over chest and proximal extremities (***Fig.* 1**). Except for neonatal jaundice his systemic examination and investigative profile were essentially normal. Wright's stained smears from a vesiclulo-pustule showed eosinophils predominately. A clinical diagnosis of erythema toxicum neonatorum was made and the parents were counseled about benign and self limiting nature of the disease. All pustular lesions subsided on day 6 of life with urticaria-like erythema or mild desquamation at places.

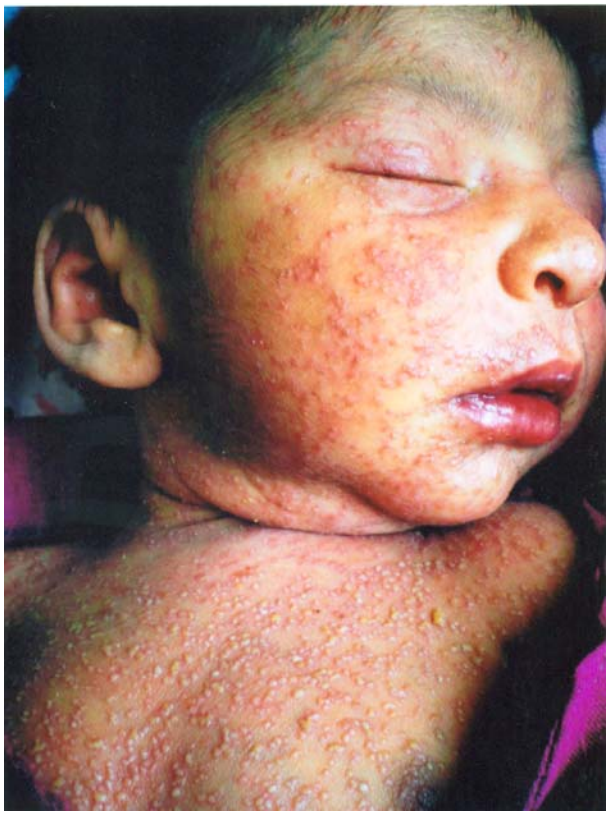

FIG. 1 *Small, multiple, erythematous macules, blotchy at places and topped with central vesicles or pustules.*

Erythema toxicum neonatorum or toxic erythema of the newborn is an uncommon, self-limiting, benign dermatosis of unknown etiology affecting both sexes equally. Its exact prevalence is unclear. Approximately 50% of full-term infants of all races will manifest some degree of toxic erythema in first few days of life but it is less common in premature and small-for-dates babies. The diagnosis is primarily clinical from typical skin lesions and their characterstics distribution being more profuse over front of trunk, proximal extremities with palmoplantar sparing, and face than other body areas. The lesions begin from birth to tenth day of life as blotchy erythematous macules. They fade away with in a day in mild cases or evolve into urticarial papules topped by small pustules within the erythe-matous areas in about 10% cases who manifest severely, individual lesions clear spontaneously in about 5 days and by 2 weeks of age all lesions resolve without residual hyperpigmentation.

These lesions need to be differentiated from other neonatal pustular dermatoses particularly miliaria rubra or pustular miliaria, transient neonatal pustular melanosis, bacterial, candida or *Malassezia furfur* pustulosis, and most importantly neonatal herpes simplex infection. Erythema toxicum neonatorum has larger 2-3 cm erythematous macules as compared to 2-3 cm erythema of miliaria lesions. Unlike erythema toxicum neonatorum, transient neonatal pustular melanosis lesions show predominance of neutrophils rather than eosinophils and resolve with residual pigmentation. Herpes lesions are usually painful, will coalesce and show multinucleated giant cells in Tzanck smears. Negative culture for bacteria or fungus and KOH mounts from skin lesions will exclude neonatal bacterial/fungal infections.

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