

SPOT DIAGNOSIS (IMAGE GALLERY)

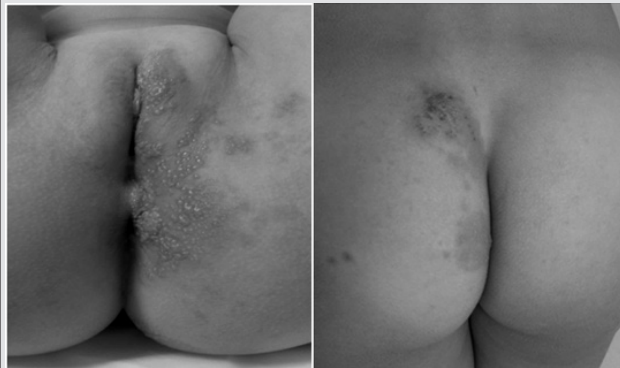


Figure 1: Grouped herpetiform vesicles located in the left labium majus, perineum and homolateral buttock

On examination, she was afebrile, in severe pain and had difficulty in walking and difficulty in pelvic movement. She had grouped herpetiform translucent vesicles developing on an erythematous base, located in the left labium majus, perineum and homolateral buttock, associated with focal eroded, exudative and crusted areas, and local parasthesia (Figure 1). There were no vulvar mucosa involvement or regional lymphadenopathies. Investigations for Varicella-Zoster Virus (VZV)-specific IgM was negative and IgG antibodies were positive, while Herpes Simplex Virus (HSV)-1 and 2 serology results were negative. She had normal hemogram, and levels of IgA, IgG and IgM were within normal range [IgA = 69 mg/dL (N: 40-350 mg/dL), IgG = 1150 mg/dL (N: 650-1600 mg/dL), IgM = 99 mg/dL (N: 50-250 mg/dL)].

What is the diagnosis?

Based on the diagnostic hypotheses of shingles or HSV infection with zosteriform distribution, she was treated with acyclovir and paracetamol, gabapentin and prednisolone. However polymerase chain reaction (PCR) for VZV in the exudate was positive while that for HSV-1 and 2 were negative.

Herpes zoster (HZ), also known as shingles, corresponds to VZV reactivation in persons with previous history of chickenpox. (1,2) Its incidence increases with age and is uncommon under the age of 15 years. (1) It is associated with primary infection in utero, immunosuppression (especially cellular immunity) and/or aging. The lesions are, characteristically, unilateral and distributed in a dermatome. (1,2) Although the diagnosis of childhood HZ can usually be made clinically, differentiating it from zosteriform HSV infection may be difficult. In those cases, direct fluorescent antibody staining and PCR method (as performed in our patient) can precisely identify the virus in skin lesion specimens. (3)

The first line of therapy for uncomplicated HZ in immunocompetent children is oral acyclovir (20 mg/kg/dose, maximum 800 mg/dose, four times a day for 5 to 7 days), while intravenous acyclovir (10 mg/kg or 500 mg/sqm, three times a day for 7 to 10 days) is the treatment of choice for immunocompromised children. (1,4) Systemic acyclovir therapy accelerates the healing of skin lesions and the resolution of acute neuritis, and decreases the risk of post-herpetic neuralgia. Due to severe pain, functional impairment and rapid extension of the lesions, our patient was admitted to the pediatric ward and was treated with intravenous acyclovir (10 mg/kg, every 8 hours), gabapentin (15 mg/kg/day, given in three divided doses) and paracetamol (15 mg/kg/dose, every 8 hours) for 7 days, and prednisolone for 3 days (1 mg/kg/day).

Funding: None

Conflict of interest: None

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DOI No. : 10.7199/ped.oncall.2017.43



GENITAL LESIONS IN A TEENAGER

Sofia Reis*, Paulo Morais**

*Department of Pediatrics and

**Department of Dermatology,

Tondela-Viseu Hospital Center, Viseu, Portugal

Address for Correspondence:

Sofia Reis, Department of Pediatrics,
Av. Rei D. Duarte, 3504-509 Viseu, Portugal.
E-mail id: reis.carlasofia@gmail.com

An 11-year-old female was treated with amoxicillin-clavulanic acid for a dental infection. She started having a burning sensation in the left buttock with progressive worsening, extending to the ipsilateral labium majus, and subsequent appearance of skin lesions in that area. There was no history of chickenpox or sexual intercourse.