Pediatric Oncall Journal (October-December)
Volume 15, Issue 4: 116
DOI : https://doi.org/10.7199/ped.oncall.2018.46

PEDIATRIC ONCALL
CHILD HEALTH CARE

IMAGES IN CLINICAL PRACTICE

ACUTE GENITAL ULCER IN A 14-MONTH-OLD GIRL

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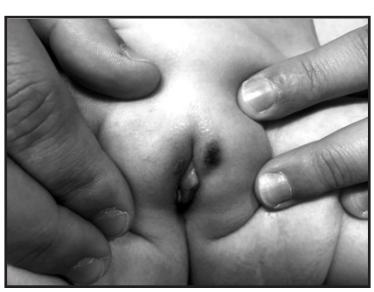
ARTICLE HISTORY
Received 2 February2018
Accepted 18 March 2018

A previously healthy 14-month-old girl, presented to the emergency room with six days of fever. One day before, parents noticed a genital ulcer. Parents also mentioned some days of diarrhoea and one day of vomiting in the previous week. There was no history of trauma, suspected sexual abuse or medications. Physical examination showed a 7mm necrotic, violaceous-edged and painful ulcer with local induration and a black crust with a grey exudate on her left major labia with a symmetrical 2mm ulcer on the right major labia ("kissing ulcers") (fig 1). There was local edema, hyperemia and a fetid smell on the left labia. Blood test revealed white cell count of 6000/cumm and C-reactive protein 6.3mg/dL. ANA was negative. Serology for herpesvirus, syphilis, hepatitis B and C, HIV, Epstein Barr virus (EBV), cytomegalovirus, mycoplasma pneumoniae and toxoplasmosis were all negative. Swabs were taken with negative results for sexually transmitted infections. Stool culture, fecal rotavirus and adenovirus antigens were also negative. She was discharged with analgesia and amoxicillin/clavulanic acid. After one day she had no fever, one week later the smaller ulcer was resolved and four weeks later the left major labia ulcer was also resolved with no scarring.

What is the diagnosis?



Lipschutz ulcer (LU), also known as acute genital ulcer, is an uncommon and an unrecognized cause of genital lesion.(1,2) Some series demonstrated that LU can be found between ages 10 and 79 years.(1) However, there are very few reports on literature describing LU in infants. (3,4) Despite crescent recognition of LU, the aetiologies and mechanisms are not well understood and nearly 70% of cases are still classified as idiopathic (1,3,5), although several viruses (EBV, CMV, Paramyxoviridae, Parvovirus B19, Influenza or Adenovirus), bacteria (Salmonella, Mycoplasma Pneumoniae or Borrelia Burgdorferi) and parasites (Toxoplasma gondii) have been associated with LU. EBV is reported in 9.7 to 30% of cases.(2,5,6) It is generally preceded by fever and a flu-like syndrome, with general malaise, headache, myalgia and, sometimes, with diarrhoea and respiratory symptoms.(1-3) The ulcer has an abrupt onset and is painful.(1-5) Diagnosis is clinical, after the exclusion of the most frequent sexually transmitted and non-infectious causes of genital ulcers.(1-3) Some authors divided LU in two forms: one gangrenous, when the ulcer is deep, violaceous-edged with a necrotic base and an adherent dark crust, usually about 1cm, associated with systemic symptoms, and tend to leave scars; and a milder form, when the ulcer is superficial, smaller, with no associated symptoms and resolves quickly without scarring.(1,2) Minor labia are the principal location of LU but it can affect major labia, perineum and the lower part of vagina.(2) The right side is more frequent but several reports describe bilateral symmetrical lesion, like "kissing ulcers", as described in the presented case. (2) Treatment is mainly analgesic, local (sitz baths, lidocaine or xylocaine) and systemic (non-steroidal anti-inflammatory).(2) Antibiotics (mainly amoxicillin/clavulanic acid) have been used to bacteria overinfection, vulvar cellulitis and, in some cases, to gangrenous form.(2) Healing usually occurs in less than six weeks.(3)

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Compliance with Ethical Standards

Funding: None

Conflict of Interest: None

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