SELF ASSESSMENT PROGRAMME

A 10 day old male child presented with a five day history of vesicobullous lesions appearing in the groins, axillae, on the face and in a limited way on the other parts of the body. The lesions would start as erythematous macules, soon turn into vesicles and bullae. A few of them turned opalescent, ruptured easily and had not healed by the time the patient presented. The patient had mild diarrhoea for three days and lowgrade fever for one day; no vomiting. The child was born full term normal, delivered at home. He was on top feeds from the first day. The child was second in order; the other sibling, two-year old is healthy. There was no history of miscarriages in the mother.

Examination showed denuded areas with over-hanging scales and some dirty yellow to brownish crusts present in the groins, axillae, face and a few on scalp and trunk, there were two large flaccid bullae with opalescent fluid, on the thighs. There was a red areola around the lesions. The child looked dehydrated and listless; skin was loose; the cry was not hoarse. No mucosal lesions were seen. There was no lymphadenopathy. Which of the following possibilities is most likely?

1. Congenital syphilis
2. Epidermolysis bullosa
3. Bullous impetigo
4. Acrodermatitis enteropathica

Which of the following investigations is most likely to help in the diagnosis?

1. Skin biopsy
2. Smear from the bulla
3. S T S of the parents and/or of the child.
4. Serum Zinc levels
5. None of these

The serological tests for syphilis from the child and the parents were non-reactive. A smear from the base of bulla showed plenty of polymorphonuclear leukocytes and ingested bacteria. Skin biopsy could not be performed.

Which of the following treatments is most likely to help?

1. Penicillin
2. Erythromycin
3. Zinc sulphate

The patient was given erythromycin 62.5 mg. four times a day and improved within a couple of days.

Should this child have been admitted to the hospital, Paediatric ward or treated at home?

The child was, in all probability suffering from bullous impetigo. The lesions started as macules developed into vesicles and some of them had been getting opalescent. The palms and soles were completely free. There were no snuffles, mucosal lesions or lymphadenopathy. The cry was normal and so was the obstetric history of the mother. Congenital syphilis is, therefore regarded as unlikely. The absence of lesions on the acral parts more prone to trauma during parturition, presence of discrete, rather well-defined lesions on other parts of the body disfavoured the diagnosis of epidermolysis bullosa.

The lesions were too acute, not necessarily concentrated around the orifices to merit consideration of acrodermatitis enteropathica.

The investigation most likely to help was a biopsy of the skin lesion which would have shown the cellular characteristics and the morphological features of the lesion. The serological tests were done as a routine to exclude the possibility of a positive serology in the patients. The smear showed plenty of Gram positive cocci and Polymorphs and substantiated a diagnosis of bullous impetigo.

While penicillin would have been effective for bullous impetigo, erythromycin was preferred in view of the possible resistance of staph to penicillins.

The child should preferably not have been admitted in the hospital because of danger of possible spread of infection in the paediatric wards. He was admitted because of poor general condition.

Untreated or inadequately treated, the disease carried high mortality in the past and was therefore called pemphigus neonatorum. With the advent of antibiotics the prognosis to life and complete cure of the disease is excellent.

Compiled by

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