

Dermatology Digest

JOE R. MONROE, PA-C, MPAS



FIGURE 1
Papulosquamous rash
on a child's elbow

What caused the rash on this elbow?

Joe Monroe practices in the dermatology department of the Warren Clinic, Tulsa, Oklahoma, is the department editor for *Dermatology Digest*, and is the founder and a past president of the Society of Dermatology Physician Assistants. He has indicated no relationships to disclose relating to the content of this article.

›CASE

A 4-year-old girl was referred to dermatology by her pediatrician for evaluation of a slightly itchy rash on her arms, legs, and buttocks that had been present for 2 weeks. The child had had a recent upper respiratory infection. Her pediatrician thought she had made a complete recovery; however, the symptoms of her respiratory infection persisted, and blood tests were performed. Results were positive for Epstein-Barr virus. The rash was first noticed around the time the test results were received. This child was not atopic, not given to rashes in general, and had no family history of skin diseases such as psoriasis.

Physical examination The child was not in any distress. A dense, fine, monomorphic papulosquamous rash covered the extensor surfaces of her arms and legs (see Figure 1). The antecubital and popliteal spaces, as well as the palms, soles, and trunk, were distinctly spared. KOH (potassium hydroxide) testing of the rash scales failed to show any fungal elements. There were no pits in the nails, and the scalp was not involved.

›WHAT IS THE MOST LIKELY DIAGNOSIS?

- Papular acrodermatitis of childhood
- Contact dermatitis
- Atopic dermatitis
- Psoriasis

›DISCUSSION

The patient had papular acrodermatitis of childhood, a condition that is also known as *Gianotti-Crosti syndrome* (GCS). This is a papulosquamous eruption associated with infection with coxsackievirus, parainfluenza, and Epstein-Barr virus, as well as with other viral infections. GCS was originally described in Italian children who were found to have anicteric hepatitis B infection. The condition is notable for sparing the warmer areas of the body,

such as popliteal and antecubital skin, and for being confined mostly to the extremities, as in this patient.

Comment Originally described in 1955 by Crosti, this relatively common eruption is harmless but can appear impressive and be worrisome to parents. The differential diagnosis for papular acrodermatitis of childhood is extensive and includes lichen planus, lichen nitidus, and scabies, in addition to the aforementioned conditions.

Contact dermatitis is an unlikely diagnosis in this child for a number of reasons. For example, this condition is not likely to produce the diffuse, symmetrical rash seen on this patient. Contact dermatitis is more likely to manifest as a patterned papulovesicular eruption.

Atopic dermatitis would preferentially affect the antecubital and popliteal areas, not spare them. Therefore, this also is an unlikely diagnosis.

Psoriasis was actually seriously considered as a possibility when the child was evaluated, but it was deemed unlikely because of the morphologic composition of the rash and the lack of a corroborative history or involvement of other areas. Psoriasis can manifest acutely with small lesions called *guttate* (which means *droplike*), but it seldom manifests as such fine, small papules.

Treatment Most experts advise against treating GCS with corticosteroids unless the patient is symptomatic, with pruritus occurring in about 25% of cases. Fortunately, GCS resolves on its own, although it can take as long as 2 to 3 months to completely clear. This often results in multiple return visits unless the correct diagnosis is made initially. The keys to making an accurate diagnosis are observation of the areas involved and spared (such as the antecubital and popliteal areas), the presence of a concomitant or recent viral illness, and the monomorphic nature of the rash. **JAAPA**