This 7-year-old boy was recently brought to my office having received a diagnosis of pemphigus foliaceus. His parents were seeking a second opinion.

Case 1:

This young child presented with an inflammatory plaque that was intensely "itchy and burny." It was the third time the lesion had occurred in the same location and it was always associated with sore knees following gym class. Can you identify the cause?

**Case 1:** This is a **fixed drug eruption** caused by the NSAIDs that the patient took to alleviate the discomfort in his knees. The most telling diagnostic clue is the recurrence of the lesions in the same location with each appearance. The individual lesions are very well defined, dusky, violaceous to blue-brown, edematous plaques that may be surmounted by multiple vesicles that coalesce into large bullae. The lesions resolve spontaneously in approximately 14 days and leave a characteristic post-inflammatory hyperpigmentation to "mark" the spot for the next recurrence. The most common locations are the lips and genitalia, but the arms and legs are also common. The lesions are most often solitary, but multiple lesions are not uncommon.

The drugs most commonly implicated in the development of a fixed drug eruption are the barbiturates, sulfonamides, tetracyclines, acetaminophen, and NSAIDs. The eruption occurs with each and every exposure to the drug and the reaction may be more intense with each exposure. Unfortunately, there is no effective therapy although most practitioners try using a super-potent topical corticosteroid.

Case 2:

These young men presented with "ringworm" that they thought they had acquired by working after school with animals. Their primary physician had treated them with topical antifungal agents and referred the boys to me to treat a presumed resistant fungal infection.

Do you recognize the lesions?

**Case 2:** This is **granuloma annulare** (GA), a common skin condition of childhood that affects girls more often than boys. The most common presentation is an annular plaque that occurs on the dorsal aspect of the hands and feet or about the joints of the fingers. The plaques are flesh-colored to violaceous and have a papular border without any epidermal change. There is a clear central area that often appears slightly atrophic.

The lesions begin as an inflammatory papule that slowly expands into an annular plaque that may grow to several centimeters in diameter. In over half of affected patients, there are multiple plaques. The lesions are always asymptomatic.

GA is most commonly misdiagnosed as a fungal infection because of its ring structure, but the clinical distinction is the lack of scale in GA. Sarcoidosis is another consideration that can cause confusion. However, GA most often occurs peripherally and does not often affect the face as sarcoidosis tends to do. A biopsy may be needed to differentiate these 2 conditions.

There are 2 other forms of GA:
- **The subcutaneous variant** generally presents as nodules that attempt to form rings over the dorsal aspect of the feet or on the anterior shins. The lesions may produce pain in the foot when they interfere with footwear. I have occasionally requested surgical excision because of lesion size or location on the foot relative to the shoe.
- **The generalized form** is most common in adults. Skin lesions may be single papules, nodules, or plaques: hundreds of lesions are widely disseminated. The generalized form of GA has been associated with diabetes mellitus in adults. There is conflicting evidence in the medical literature about the association of diabetes and isolated lesions of GA. Therefore, I recommend that this association be recognized--and that children receive a screening evaluation for diabetes every few
years as part of their routine care. Approximately three quarters of all GA lesions disappear spontaneously within 2 years. Parents need to be reassured of the banal nature of the condition, and most affected children can be managed with time. When a parent requests therapy, however, I will prescribe a potent corticosteroid. This may involve an injection (eg, triamcinolone 2.5 mg/µL) or topical applications (during a 4-week trial) to the peripheral palpable border. Unfortunately, such therapy is not usually very effective. A large number of other topical and systemic treatments have been tried for the treatment of GA but their sheer number suggests their lack of efficacy. I generally avoid them.

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