Picture of the Month

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A 7-MONTH-OLD BOY HAD A 3-WEEK HISTORY of nonbloody diarrhea and increasing irritability. The mother reported a perioral and anogenital erythematous rash that first appeared in the third month of life with variable severity but never resolved. In the 4 months prior to admission, various visits to family doctors and hospitals with multiple courses of oral antibiotic treatments and different ointments led only to brief improvements of the skin condition with subsequent relapses. A trial with corticosteroids for suspected psoriasis caused a severe deterioration. The perinatal history was noncontributory: the boy was born at term after an unremarkable pregnancy, was fully breastfed, and developed appropriately along the 75th percentile for height and weight.

On admission, the child was afebrile (rectal temperature, 37.1°C) with all vital signs within normal limits, but he was irritable and crying a lot. The physical examination revealed sharply demarcated, erythematous, and in some areas ulcerating and scaling skin lesions predominantly located in the anogenital area and periorally with signs of bacterial superinfection (**Figure 1** and **Figure 2**). Apart from the irritability and the skin lesions, the physical examination results were unremarkable; in particular, there were no signs of dehydration or wasting disease. Initial laboratory studies showed a normal complete blood cell count, an erythrocyte sedimentation rate of 18 mm/h (reference range, 0-10 mm/h), an aspartate aminotransferase level of 36 U/L (reference range, 7-28 U/L [to convert to microkatal per liter, multiply by 0.0167]), and an alkaline phosphatase level of 57 U/L (reference range, 170-450 U/L; photometric [to convert to microkatal per liter, multiply by 0.0167]).

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Figure 1. Skin lesions at the initial visit. Note the sharply demarcated, erythematous, and scaling character with ulcerations near the demarcation line.

Figure 2. Close-up view of the skin lesions at the initial visit.

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