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DERMATOLOGY CLINIC
What's Your Diagnosis?

UNILATERAL RASH IN A TODDLER

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A 20-month-old male presents to your busy, winter, flu-ridden clinic for evaluation of a persistent, spreading rash that began in the left axilla and is spreading locally to the peri-axillary area and left trunk area (see photo). There is no similar rash on right axilla/trunk, nor is there a similar rash in the neck or inguinal folds. Rash is comprised of pink flat spots and pink bumps, with some scaly patches. It has been present for 2 weeks. He is not scratching or visibly uncomfortable. He has no household contacts with a similar rash. Mom denies using any new soaps, lotions or laundry products. Upon questioning, mom reveals that he might have had a runny nose and low-grade fever about a month ago.

What is your diagnosis?

A) UNILATERAL LATEROTHORACIC EXANTHEM

B) CONTACT DERMATITIS

C) SEBORRHEIC DERMATITIS

D) TINEA CORPORIS

ANSWER:

A) UNILATERAL LATEROTHORACIC EXANTHEM (aka Unilateral Periflexural Exanthem of Childhood)

As the name suggests, this is a unilateral, localized rash that usually begins in or near the armpit, chest, trunk or inguinal fold. It is self-limited and can take up to 4-6 weeks to resolve. It is thought to be a reactive process to an antecedent viral infection (upper respiratory or gastrointestinal), but no specific infectious agent has been identified. It is most commonly seen in infancy and early childhood (age 2-3 years of age, but has been observed in younger infants, older children, and, rarely, adults). There is a 2:1 female:male predominance, and it usually develops in the winter/spring months. It presents as discrete 1-2mm pink papules that coalesce into annular or reticulate plaques. It can be associated with ill-defined eczematous patches, as well. The initial rash spreads centrifugally, tends to progress into a scalier rash, that then resolves with fine, superficial peeling. In up to 70% of cases, the rash will spread to the contralateral side or spread to involve the face, groin, palms/soles over the 4-week interim, but it will be most prominent at the original site. It will never involve the mucous membranes. It is usually asymptomatic, but can be mildly itchy. The rash itself is not contagious, but the antecedent viral infection can be. The asymmetry of the rash, the extension from a flexural area, and the young age help make the diagnosis. Treatment is symptomatic only. Oral antihistamines can help itchy children sleep, while mild topical steroids can help reduce inflammation, redness and itch.

Other Options:

CONTACT DERMATITIS

An allergic or irritant contact dermatitis can develop after a single or multiple, repeated exposures to a particular chemical or natural compound. It can take days or weeks for the rash to erupt. It can present as localized, itchy or irritated pink-red papules or blisters superimposed on a pink base. It develops at the site of skin exposure and it does not spread. It is also not specifically asymmetric. Certain chemicals (including laundering chemicals and topical personal hygiene products) have a predilection for causing irritation in flexures, but those exposures are not clinically relevant in this case. Management includes identifying and avoiding the chemical, and treating the rash with a short course of topical steroids.

SEBORRHEIC DERMATITIS

Akin to cradle cap, this rash can present as pink-red greasy or dry scaly papules and patches in flexural areas, including the perinasal, post-auricular, axillary and inguinal folds. It is thought to be associated with a triad of abnormal sebum production, yeast on the skin (*Malassezia furfur*), and a pro-inflammatory skin response. It is symmetrical. It is usually asymptomatic, but can be mildly itchy or irritated. Infants tend to outgrow this condition, but in teens and adults, it tends to wax and wane. Management involves topical anti-yeast and anti-inflammatory agents, as needed.

TINEA CORPORIS

Superficial dermatophyte (fungal) infections appear as discrete pink plaques with raised scaly edges and central clearing. They can be contagious through direct skin to skin contact, and tend to develop in kids who play contact sports or are in frequent contact with puppies/kittens. Diagnosis can be made via microscopic examination of a skin scraping treated with KOH (potassium hydroxide). Treatment includes topical antifungal creams for 2-4 weeks. Superficial yeast (Candida sp) infections can have a similar red, scaly appearance with or without the central clearing or a rim of fine, superficial scale, and are more commonly seen in skin folds. Eruptions in the skin folds can appear macerated, rather than dry and scaly. They can spread larger or via smaller, satellite lesions. Secondary rashes can develop as an immune response to the infection, called an Id Reaction. These rashes tend to symmetric. They are treated with topical anti-yeast creams.

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