An 8-Year-Old Male with Generalized Itchy and Scaly Rash for 3 Weeks

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A n 8-year-old male presented to the emergency department complaining of pruritic generalized body rash that had been present for 3 weeks. The rash began on the trunk and the proximal extremities and then progressed to involve the face, the ears, and the scalp over the following 3 weeks (Figures 1 and 2). On the second day of the rash the patient’s mother took him to an urgent care facility for evaluation, where they were told that the rash was an allergic reaction and he was given a second-generation antihistamine. There was no improvement with the antihistamine. In addition, the mother used over-the-counter diphenhydramine to control the continued discomfort of the itching and burning. The patient denied fever, chills, sore throat, vomiting, abdominal pain, or current viral-like symptoms. The patient also denied past or current use of medications and any known allergy.

Upon further inquiry, it seems that the boy had a 1-day history of sore throat 1 week prior to the appearance of the rash, but it resolved without further intervention. His older sister had been diagnosed a few days earlier with streptococcal pharyngitis.

Upon physical examination, the child appeared healthy and well developed. His entire body, except for the palms of his hands and soles of his feet, appeared to be covered with numerous discrete, drop-like papules with a salmon-pink hue. Also, fine scales and white crusts on an erythematous base were seen (Figures 2 and 3). Otherwise, the rest of the exam was unremarkable, including normal-appearing throat, perianal region, and nails.

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Figure 1. Numerous discrete, drop-like papules with a salmon-pink hue are seen on the back.
The patient presented with the typical skin lesions characteristic of guttate psoriasis (GP). He developed pharyngitis following exposure to his sister 1 week prior to the appearance of the rash. There were no nail changes in the form of pits, ridges, or the oil-drop sign seen on examination. A streptococcal throat culture was positive and the patient was started on a 10-day course of amoxicillin.

DISCUSSION

The guttate variant of psoriasis is relatively uncommon and has a distinctive clinical presentation that is characterized by acute eruption of small, drop-like, red (salmon-pink) papules, usually with fine scales, as seen in our patient. Usually, those fine scales seen on the drop-like lesions are much finer than those scales seen in plaque psoriasis, which is the most common type of psoriasis. The rash of GP usually appears first on the trunk and both extremities, then spreads to involve the face, the ears, and the scalp. The palms and the soles are usually spared. Nail changes in the form of pits and ridges are characteristic of chronic psoriasis.

GP is usually triggered by a streptococcal throat infection (Streptococcus pyogenes); however, the eruption does not present right away and can take 2 to 3 weeks to appear. Also, streptococcal perianal skin infection in children has been associated with the appearance of GP. The precise mechanism by which streptococcal infections induce psoriasis is not fully understood. Other infections, such as chickenpox, rubella, and roseola, have been linked to the appearance of GP in children. Also, several drugs have been implicated in either precipitating GP or triggering a guttate-type flare. Commonly implicated agents are lithium, beta-blockers, and nonsteroidal anti-inflammatory drugs.

The scaly pruritic lesions of GP can be easily differentiated from other similar conditions such as nummular dermatitis, guttate parapsoriasis, pityriasis lichenoides, pityriasis rosea, and tinea corporis.

Generally, GP resolves spontaneously over several weeks with simple measures, such as using skin moisturizer. Proper counseling and assurance of parents regarding the benign nature
of this condition are also important. Antibiotic treatment of streptococcal infection should be considered if either throat or perianal culture is positive.

There is no consensus on a specific approach to treat GP. As with other dermatologic conditions, the treatment approach should be tailored to the individual. For instance, if GP develops as a reaction to a new medication, discontinuation of the offending drug may be needed, particularly if other treatments do not improve the symptoms.

Topical steroids are quite effective but their application can be difficult, especially when the eruption is widely spread. When applied extensively, steroids should be used with caution in children because fluorinated compounds can cause cutaneous atrophy. Therefore, the least-potent effective steroids should be used.

The resolution of guttate lesions can be expedited in adults with severe cases by the use of psoralens and ultraviolet light (PUVA), but the safety of the use of PUVA in children has not been established.

GP has an overall good prognosis in children; however, the acute eruption phase may also represent the initial stage of chronic plaque-type psoriasis. In a small study of 15 patients, Martin et al. reported that the probability of a patient developing chronic psoriasis within 10 years of a single episode of acute guttate psoriasis was about 30%.

REFERENCES