Impetigo herpetiformis pdf

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ABSTRACT @# Impetigo herpetiformis is a rare pustular disorder that affects pregnant women. It is also otherwise termed as “pustular psoriasis of pregnancy”, owing to the fact that the pustules are sterile and are not associated with a viral etiology. The classic lesions are erythematous patches or plaques with margins studded with subcorneal pustules spreading centrifugally. A cardinal feature of this disorder is the rapid resolution of lesions after delivery. Case This is a case report of a 33-year-old female, gravida 3, para 2 (2-0-0-2) at 36 weeks age of gestation who presented with one week history of multiple well defined irregularly shaped erythematous annular patches and plaques with marginal pustules on the trunk and extremities. The lesions began on the trunk spreading centrifugally, sparing the face, palms, soles and mucus membrane. Biopsy showed scale crust in the stratum corneum, the epidermis showed acanthosis, spongiosis and neutrophilic microabscesses with focal vacuolar alteration and small sub-epidermal nests on the basal cell layer. The dermis revealed dilated blood vessels and mild superficial perivascular lymphocytic infiltrates. Patient was given Prednisone and Cetirizine with noted resolution of lesions. Recurrences of impetigo herpetiformis in subsequent pregnancies are common with earlier onset in gestation and are characteristically more severe. The complications are placental insufficiency, stillbirth or neonatal death. Early detection is of utmost importance. Management must be multidisciplinary involving a dermatologist, obstetrician and pediatrician. Assuntos Buscar no Google Base de dados: WPRIM Assunto principal: Psoríase / Feminino / Gravidez / Dermatopatias Vesiculobolhosas / Exantema / Impetigo Idioma: Inglês Revista: Journal of the Philippine Dermatological Society Ano de publicação: 2020 Tipo de documento: Artigo Buscar no Google Base de dados: WPRIM Assunto principal: Psoríase / Feminino / Gravidez / Dermatopatias Vesiculobolhosas / Exantema / Impetigo Idioma: Inglês Revista: Journal of the Philippine Dermatological Society Ano de publicação: 2020 Tipo de documento: Artigo Impetigo herpetiformis is a rare condition that has been reported in fewer than 100 pregnant women. The disease is similar to a type of psoriasis that's called pustular psoriasis, although women with impetigo herpetiformis usually have no personal or family history of psoriasis. Doctors disagree about whether it is a distinct disease that's caused by pregnancy or a form of pustular psoriasis that's triggered by pregnancy. Despite the name "herpetiformis," the rash is not caused by a herpes virus. It is named "herpetiformis " based on the appearance of the pustules, which can look like those that are caused by herpes viruses (such as chickenpox.) Impetigo herpetiformis is unrelated to a similarly named condition called dermatitis herpetiformis, a rash that has been coined the "celiac rash." The rash begins as pus-filled bumps, or pustules, on the edges of a red area of skin on the inner thighs and groin. The pustules join and spread to the trunk and extremities, usually sparing the face, hands, and feet. However, the rash can spread to the mucous membranes of the mouth and the nail beds. Pus is present, but these lesions are not infected with bacteria, though they can become infected throughout the course of the disease. Impetigo herpetiformis typically begins in the last trimester of pregnancy. The rash usually resolves after delivery but can recur in subsequent pregnancies. Women who have a parathyroid disorder called hypoparathyroidism may be susceptible to this condition during pregnancy as calcium and albumin levels in the blood fall. It's also currently thought that women who have certain gene mutations may be at a greater risk of developing the rash. It's not known why the rash occurs during pregnancy but not at other times. However, there are many skin changes that normally occur during pregnancy. Impetigo herpetiformis is frequently accompanied by significant symptoms such as fever, chills, nausea, vomiting, diarrhea, and fatigue. Some women experience low levels of calcium and phosphate in the blood. Impetigo herpetiformis is usually diagnosed by its symptoms and its characteristic rash. A skin biopsy is typically performed to rule out other pregnancy-related conditions. Some studies have linked the condition to genetic mutations, so it is possible that some physicians may order genetic testing. There are many types of rashes that can be seen in pregnancy. A fairly common rash called pruritic urticarial papules and plaques in pregnancy (also known as PUPPP, PUPPS, or PEP) occurs in one out of every 160 pregnant women. Similar to impetigo herpetiformis, this rash most often occurs in the third trimester of pregnancy, but in contrast, it tends to be very itchy. Impetigo herpetiformis is treated with the oral steroid prednisone. The beginning dose is usually fairly high and then it's tapered very slowly once symptoms are under control. Sometimes steroids are not well tolerated. If this is the case, then other medications may be used. Antibiotics are used only if the rash becomes secondarily infected. Blood levels of calcium, phosphate, and albumin are monitored throughout the course of the disease. According to research, impetigo herpetiformis is associated with the risk of stillbirth and placental insufficiency. Early recognition is important to reduce both maternal and fetal morbidity. Women with this condition should be closely monitored by a team of physicians to include dermatologists, obstetricians, and pediatricians. So if you suspect that you may have impetigo herpetiformis, call your doctor right away. To the Editor: Impetigo herpetiformis (IH) is a rare pruritic pustular dermatosis of pregnancy; only about 110 cases had been documented up to 2004. We report a case of IH that did not respond to oral corticosteroids and was subsequently treated successfully with cyclosporine.A 30 year-old Asian woman presented with a pruritic, pustular eruption noted on her arms, legs, and buttocks of 2 weeks' duration. She was in week 30 of her first, otherwise uncomplicated, pregnancy. She noticed small red itchy bumps on her shin, which later spread to her upper arms and buttocks. She denied any constitutional symptoms. She is of Chinese descent with a known history of chickenpox as a child and recurrent, monthly, oral herpetic lesions.Physical examination revealed a healthy-looking, apyrexial Asian woman. Bilaterally on the cheeks, back, abdomen, arms, legs, buttocks, dorsal hands were widely scattered, 1- to 3-mm, inflamed papules and pustules with poorly defined surrounding erythema; several were grouped into plaques and some had yellow crust that were overlaid with excoriation (Fig 1).Fig 1Abdomen of patient on first visit. There are countless 2- to 3-mm erythematous papules and pustules with several coalescing into plaques.Tzanck preparations as well as viral and bacterial cultures all yielded negative results. A skin biopsy specimen showed scale-crust, erosion, psoriasiform epidermal hyperplasia and a heavy infiltrate of neutrophils in the upper epidermal layers with formation of spongiform pustules. There was also mild diffuse spongiosis with neutrophilic exocytosis and a mild superficial and perivascular lymphocytic infiltrate with scattered eosinophils, occasional mast cells, and mildly increased interstitial mucin. All of these findings were consistent with IH (Fig 2). No histopathologic changes of herpesvirus infection were identified. Periodic acid–Schiff staining was negative for fungal organisms.Fig 2Histologic features of impetigo herpetiformis. A, Low power shows scale-crust with neutrophils, erosion, psoriasiform epidermal hyperplasia, and a spongiform pustule. Inset: Detail of spongiform pustule containing neutrophils and occasional eosinophils. B, Higher power reveals parakeratosis and pale hypogranulotic epidermis containing neutrophils. (A and B, Hematoxylin-eosin stain; original magnifications: A, ×40, inset ×400; B, ×400.)The patient was treated with oral prednisone started at 1 mg/kg (60 mg) and tapered over 3 weeks. After 6 days of treatment her skin lesions continued to progress, and she experienced increasing discomfort. Cyclosporine was initiated at a dosage of 4 mg/kg per day (300 mg daily), and the prednisone was tapered over the following week. Within 5 days of starting cyclosporine, she felt more comfortable and new skin lesions stopped developing. After 5 weeks of 300 mg/d of cyclosporine, she had almost 90% clearing of her skin, and the dosage was decreased to 200 mg daily. Topical clobetasol ointment was prescribed for symptomatic lesions. Two weeks later the cyclosporine dose was decreased to 100 mg daily. The cyclosporine was discontinued 3 days before her delivery date as the patient was planning to breast-feed., The disease occurs most often during the third trimester of pregnancy and earlier in subsequent pregnancies. Laboratory findings have included leukocytosis, elevated erythrocyte sedimentation rate, hypocalcemia, hypoalbuminemia, and low thyroid hormone levels., , Our patient did not demonstrate any of these findings.Our patient responded well to oral cyclosporine treatment. Toward the end of the third trimester, the dose was slowly tapered. The last dose was given 3 days before vaginal delivery of a healthy baby girl. The patient was maintained on a regimen of topical high-potency corticosteroid and emollient. One month after delivery, the patient was seen in follow-up and had scattered new lesions. She continued to control these new IH eruptions with topical corticosteroids only. The baby was healthy and shows no evidence of growth retardation or immunosuppression.DOI: © 2007 American Academy of Dermatology, Inc. Published by Elsevier Inc. All rights reserved.Access this article on ScienceDirect

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