Atrophoderma Vermiculatum

A 10-year-old boy presented with multiple asymptomatic small pit like areas of atrophy present over the preceding 8 years. There was no history of inflammatory papules prior to the development of the scars. Family history was non-contributory. Cutaneous examination revealed bilaterally symmetrical pitted, atrophic and depressed scars in a honeycomb pattern. (***Fig.* 1**) Histopathology showed epidermal atrophy, dilated capillaries and sclerosis of dermal collagen. A diagnosis of Atrophoderma vermiculatum was made; topical tretinoin was prescribed.

Atrophoderma vermiculatum, a disorder limited to the face usually has its onset during childhood or puberty and has a slow progressive course. The underlying pathogenesis appears to be abnormal follicular hyperkeratinization. It may be associated with congenital heart block, neurofibromatosis, oligophrenia or Down syndrome. Other atrophies which simulate this are post-acne scarring (history of acne, postpubertal onset) and viral varioliform scarring (history of viral exanthem). Various topical treatments, including emollients, corticosteroids, tretinoin and keratolytics, have not shown consistent benefit.

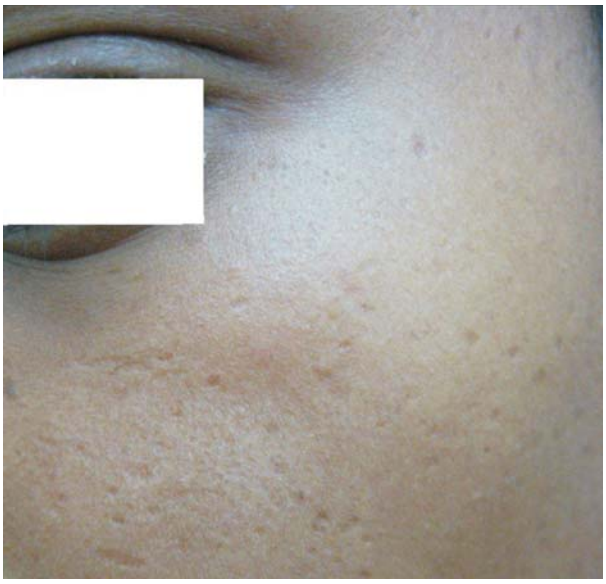

FIG. 1 *Pitted, atrophic and depressed scars in a honeycomb pattern.*

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Non-bullous Congenital Ichthyosiform Erythroderma

A 4-day-old neonate was brought with complaints of fissuring and peeling of skin involving almost the whole body. The neonate had generalized desquamation not even sparing the palms, soles and face. The parents informed that the baby was born, enclosed in a constricting parchment-like membrane (collodion baby) that had gradually come-off. There was a past history of a child born with similar presentation in the previous pregnancy. There was no history of consanguinity.

On examination, the entire body surface showed extensive fissuring and peeling of skin (***Fig.*1**). Diffuse erythema and scaling was also noted, scales being larger on the legs and finer at other places. No bullae, vesicles or quadrilateral scales could be found. There was no ectropion, eclabium or cicatricial alopecia. On histological examination, parakeratosis and perivascular neutrophilic infiltration was present. The neonate was advised symptomatic treatment with topical keratolytics and emollients.

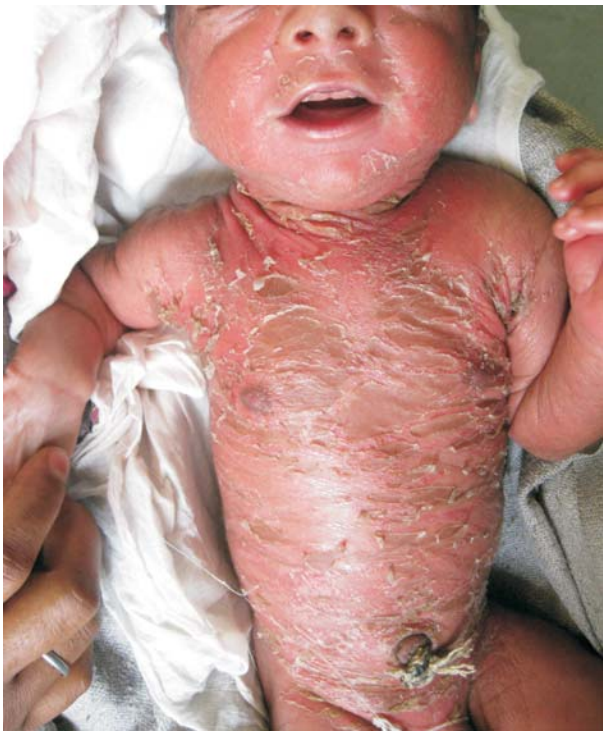

FIG. 1 *Generalized fissuring and peeling of skin.*

Non-bullous congenital ichthyosiform erythroderma belongs to the family of autosomal-recessive ichthyosis. Lamellar ichthyosis (large, quadrilateral scales adherent at the centre) and Harlequin fetus are the other ichthyosiform disorders transmitted in recessive fashion. Apart from these varieties, ichthyosis may be autosomal dominant (Ichthyosis vulgaris; characterized by sparing of the flexures and presence of features suggestive of atopic dermatitis and keratosis pilaris) or *X*-linked ichthyosis (history of prolonged labor, only in males, presence of cryptorchidism, characteristic pre-auricular involvement).

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Crusted Scabies

A 4-month-old HIV-positive infant staying at an orphanage presented with papular lesions all over the body (***Fig.* 1**) and crusted scaly lesions over the palms and soles over a period of two months (***Fig.* 2**). Several other inmates had also developed similar lesions. A clinical diagnosis of crusted scabies was made and all the inmates of the orphanage, including this patient, were treated with 5% permethrin.

Crusted or Norwegian Scabiesis is seen in an immunocompromised host. AIDS, leprosy, lymphoma, Down syndrome and being elderly are risk factors for crusted scabies. Crusted scabies begins with poorly defined erythematous patches that quickly develop hyperkeratotic plaques diffusely over palmar and plantar regions. Itching may be minimal or absent. Differential diagnosis for crusted scabies include seborrhoeic dermatitis (greasy, scaly, erythematous papular dermatitis usually involving the face, neck, retroauricular areas, axillae and diaper area), Langerhans cell histiocytosis (associated with localized or generalized lymphadenopathy, hepatosplenomegaly, chronic ear discharge, pulmonary infiltrates and bone lesions), psoriasis (demarcated scaly lesions, pinpoint bleeding on removal of a scale, Koebner response and characteristic nail changes), and ichthyosis vulgaris (scaly lesions predominantly in the extensor aspects of the extremities, keratosis pilaris and hyperkeratosis of the palms and soles). Demonstration of the mites in skin scraping differentiates crusted scabies from other conditions.

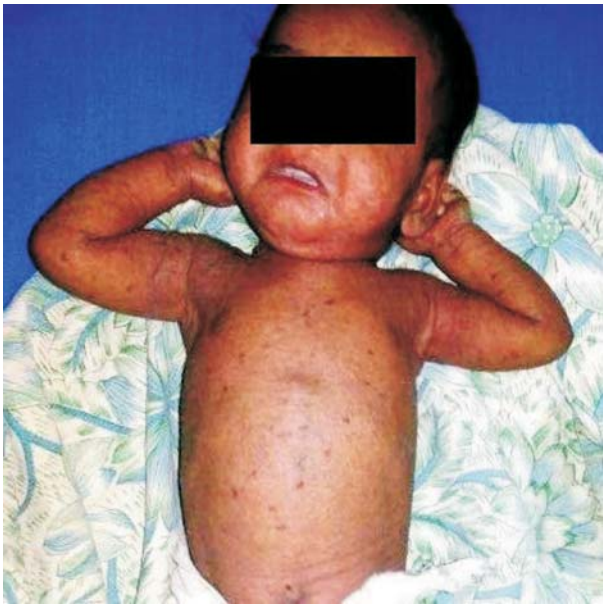

FIG. 1 *Popular lesions of scabies.*

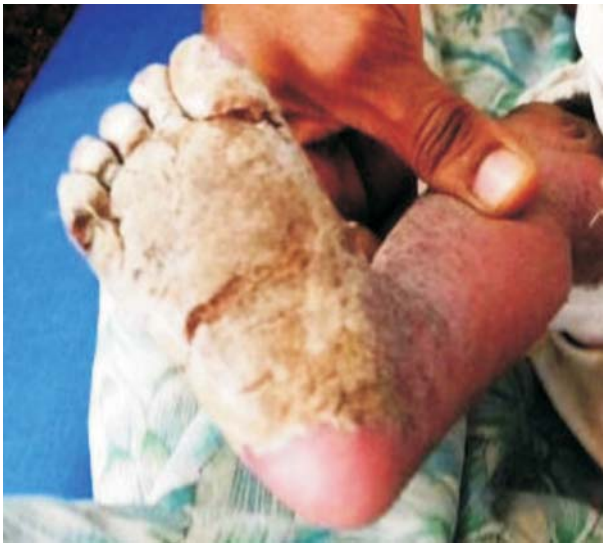

FIG. 2 *Crusted scaly lesions over sole.*

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