Journal of Clinical and Medical Images

Case Report

ISSN: 2640-9615 | Volume 6

A Case with Gianotti-Crosti Syndrome with a History of Atopic Dermatitis

Oktay MA* and Oktay SA

Department of Child Health and Diseases, Amasya, Turkey

***Corresponding author:**

Mehmet Ali Oktay,
Amasya Merzifon Karamustafa Pasa State Hospital Department of Pediatrics, Amasya, Turkey, Tel: +90 535 666 4365;
E-mail: malii-71@hotmail.com

Received: 23 Apr 2022
Accepted: 09 May 2022
Published: 14 May 2022
J Short Name: JCMI

Citation:

Oktay MA, A Case with Gianotti-Crosti Syndrome with a History of Atopic Dermatitis. J Clin Med Img. 2022; V6(8): 1-2

Keywords:

Gianotti-Crosti syndrome; Atopic Dermatitis

1. Abstract

Gianotti-Crosti syndrome (GCS) is characterized by an acute onset papular or papulovesicular rash with a symmetrical distribution. The eruption is predominantly located on the extensor surfaces of the extremities, glutea, and face. GCS is most common in children aged 1 to 6 years. Herein we present an eight-month-old male patient diagnosed with GCS with a history of atopic dermatitis. Symmetrical, multiple, monomorphic, fat-covered, erythematous pruritic lesions were detected on the face, trunk, arms and legs. The presence of atopic dermatitis was significantly higher in those with GCS, suggesting that a more common family history for atopy was significantly associated with GCS. GCS is a syndrome whose diagnosis requires a high level of clinical suspicion. It is confused with other exanthematous diseases of childhood.

2. Introduction

Gianotti-Crosti Syndrome (GCS), also known as papular acrodermatitis, childhood papular acrodermatitis, or infantile papular acrodermatitis, is characterized by an acute onset papular or papulovesicular rash with a symmetrical distribution. The eruption is predominantly located on the extension surfaces of the extremities, glutea, and face [1]. GCS is most common in children aged 1 to 6 years [1, 2]. Epstein-Barr Virus (EBV) and hepatitis B are the two most common pathogens associated with GCS, with many different viral infections (cytomegalovirus - CMV, HIV, hepatitis A, hepatitis C, parvovirus B19, parainfuenza virus type 1 and type 2, coxsakiviruses A16, Association with B4 and B15, rotavirus, echovirus, respiratory syncytial virus, rubella virus, adenovirus, enterovirus, herpes virus 6, molluscum contagiosum virus, paravaccinia virus, mumps virus) has been reported in this syndrome [1, 2]. In this piece, an eight-month-old male patient with a history of atopic dermatitis and diagnosed with Gianotti-Crosti syndrome is presented.

3. Case

An eight-month-old male patient presented with papular eruption that increased within a few days. Papules started from the legs and spread to the trunk, arms and face. The patient had flu-like symptoms a week ago. There was no history of fever, vomiting, diarrhea, recent vaccination, or a family history of COVID 19. He had a history of using hydrocortisone acetate due to a history of atopic dermatitis. There were no recent skin lesions related to atopic dermatitis. On physical examination, symmetrical, multiple, monomorphic, fat-covered, erythematous pruritic lesions were found on the face, trunk, arms and legs (Figure 1 and 2). No lesions were observed on the scalp, mucous membranes, palms and soles. The diameter of individual lesions ranged from 1-5 mm. Complete blood count and respiratory viral panel were normal in laboratory tests. Hepatitis A, B, C, herpes 1-2, CMV, EBV serology were negative. The patient was evaluated as atopic dermatitis in another center and a moisturizing cream was recommended. The patient was examined by different specialties (pediatrics, dermatology), the diagnosis of GCS was assumed to be most likely based on clinical findings and laboratory examination, and an antihistamine was given for pruritus control. The rash regressed spontaneously within 15 days.

4. Discussion

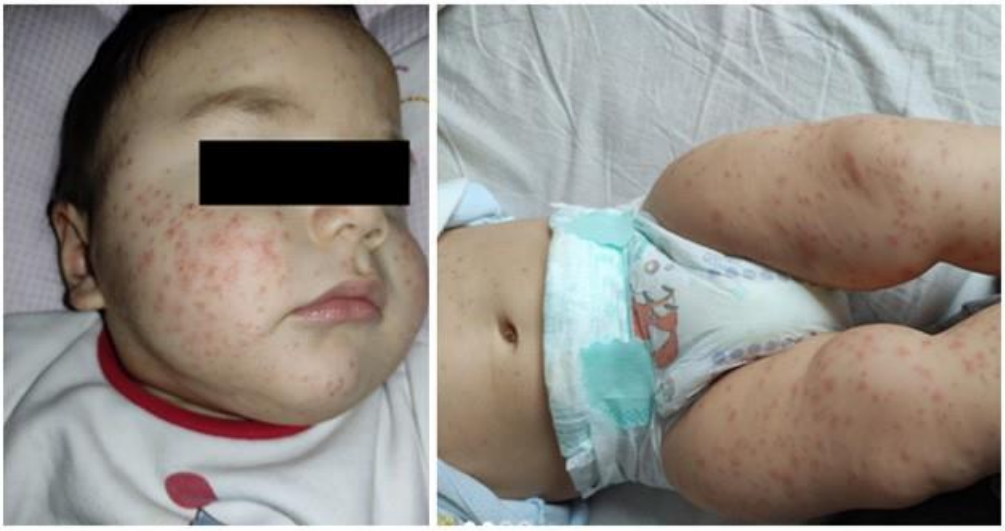

Figure 1 and 2: Multiple monomorphic, fat-covered, erythematous pruritic papules lesions

Gianotti-Crosti Syndrome (GCS) is a self-limiting condition that primarily affects children younger than 6 years of age and is less common in adolescents and adults. It consists of a viral exanthema that predominantly affects the extremities, gluteal region, and extensor surfaces and has flat-topped, symmetrically distributed papular lesions. It is usually associated with viral infections, but it can be associated with bacterial infections, vaccination, or idiopathic [1, 3].

GCS is a benign and self-limiting disease, therefore symptomatic and supportive measures should be a priority. For pruritus control, some sources recommend topical lotions (calamine, pramoxine, menthol, camphor, polidocanol) and oral antihistamines. Topical or systemic corticosteroids may be indicated in severe cases [3].

In differential diagnosis of GCS, atopic dermatitis, hand-foot-and-mouth disease, papular urticaria, fifth disease, erythema multiforme, scabies, drug eruption are considered [1]. Atopic dermatitis, which should be kept in mind for differential diagnosis, is a specific form of eczema and is the most common chronic inflammatory skin disease. This chronic condition associated with itching usually begins in infancy and is manifested by dry skin, eczematous lesions, and lichenification [4]. Most children with GCS have an excellent prognosis, but full recovery may take some time until the lesions disappear, often causing concern for both the patient and the family [3]. As with other differential diagnoses, differences should be considered in the differential diagnosis with atopic dermatitis. The presence of atopic dermatitis was significantly higher in those with GCS, suggesting that a more common family history for atopy was significantly associated with GCS. It has been shown that atopy plays an important role in conditioning the onset of clinical papular eruption features of GCS in children exposed to different microbiological agents [5]. The fact that our case also had a history of atopy supports this study.

The diagnosis of GCS requires a high level of clinical suspicion. It is confused with the exanthematous diseases of childhood. This disease is probably underdiagnosed. Therefore, it should be considered in the differential diagnosis of patients with atypical exanthema.

References

1. Leung AK, Sergi CM, Lam JM, Leong K. Gianotti–Crosti syndrome (papular acrodermatitis of childhood) in the era of a viral recrudescence and vaccine opposition. World Journal of Pediatrics. 2019; 15(6): 521-7.
2. Brandt O, Abeck D, Gianotti R, Burgdorf W. Gianotti-crosti syndrome. Journal of the American Academy of Dermatology. 2006; 54(1): 136-45.
3. Afonso A, Cachão J, Junior VLP, Gouveia T. Gianotti-Crosti syndrome: a challenging exanthema. BMJ Case Reports CP. 2021; 14(4): e240747.
4. Kolb L, Ferrer-Bruker SJ. Atopic Dermatitis. StatPearls. Treasure Island (FL): StatPearls Publishing Copyright © 2022, StatPearls Publishing LLC. 2022.
5. Ricci G, Patrizi A, Neri I, Specchia F, Tosti G, Masi M. Gianot- ti-Crosti syndrome and allergic background. Acta dermato-venereologica. 2003; 83(3).