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RESEARCH ARTICLE

IMPETIGO HERPETIFORMIS IN A CASE REPORTPRESENTATION OF A RARE ENTITY

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Abstract

Impetigo herpetiformis (IH) is a very rare and specific pustular dermatosis of pregnancy that can be life-threatening for both mother and child. This entity is currently considered as a variant of pustular psoriasis. We report an observation of a 35-year-old female patient who presented with extensive erythematous-pustular plaques for which the diagnosis of impetigo herpetiformiswas made clinically and histologically. The lesions appeared in the third trimester of pregnancy without fetal or maternal impact. The treatment was prednisone, vitamin D supplementation and a macrolide for 10 days.

Introduction:-

Impetigo herpetiformis (IH) is a rare generalized pustular dermatosis specific for pregnancy, posing nosological difficulties with generalized pustular psoriasis [1-2]. Although the diagnosis of IH is easy, its therapeutic management is difficult and poorly codified.

Observations:-

Mrs. L.J, 35 years old, pregnant at 32 weeks of amenorrhea, was admitted with febrile generalized exanthem. On examination, multiple circular and annular erythematous-squamous placards were noted, bordered by numerous non-follicular pustules involving the trunk and the roots of the limbs (Figure 1). The obstetrical examination was normal. The biological workup showed an inflammatory syndrome, normal blood calcium, hypoalbuminemia, and hypovitaminosis D. Histology showed subhorn-like spongiform pustules filled with neutrophils (PNN) with acanthosis, papillomatosis and parakeratosis, confirming the diagnosis of impetigo herpetiformis. The treatment combined 1 mg/kg/d of prednisone, vitamin D supplementation and a macrolide for 10 days and follow-up, with close fetal monitoring. The evolution was favourable for the mother (vaginal delivery at 37 days after birth) and the child (male, 3100 g).

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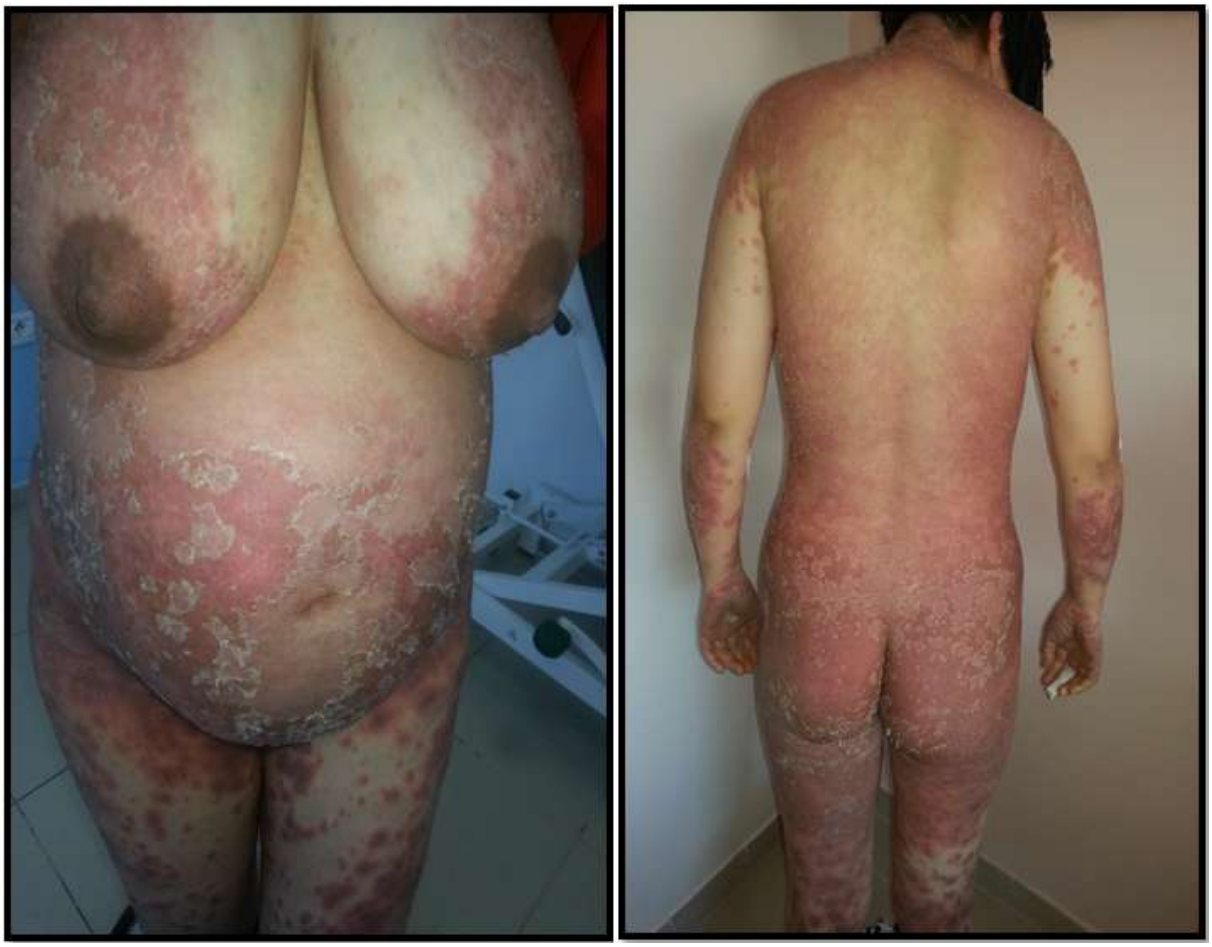

Figure 1:- Diffuse erythematouslesion and pustules.

Comments

Impetigo herpetiformis is a rare gravidic dermatosis (less than 200 cases reported), characterized by a rash often occurring in the third trimester of pregnancy that affects primiparous women in 80% of cases. Defining the etiopathogeny of IH remains difficult, however hypocalcemia, dysthyroidism [3], infection, oral contraceptives, menstruation [4] as well as stress have been incriminated in the onset of the disease. [5] It is characterized by large erythematopustular plaques of the abdomen and major folds[6]. The maternal prognosis is dominated by the risk of a toxic-infectious syndrome, which has become rare and fatal. The fetal prognosis is clouded by the risk of fetal death (20% of cases), prematurity due to placental insufficiency, fetal anomalies, hypotrophy, hydrocephalus, intracranial hypertension and malformations. Because of the often unpredictable fetal complications, close monitoring of the pregnancy is essential [7,8]. A phosphocalcic assessment for hypocalcemia and hypovitaminemia D should be performed. The diagnosis is suggested by the clinical and biological elements and confirmed by the histological aspect of the pustule, which is spongiform, subcorneal and multilocular with PNN. The therapeutic management of IH is poorly codified and the cases reported in the literature have been treated with general corticosteroid therapy alone or combined with other symptomatic treatments: calcium, vitamin D, hydroelectrolyte rebalancing, protein supplementation, nursing, antibiotic therapy if superinfection [8,9].

In our patient, the skin lesions were stabilized without true remission by general corticotherapy, with a good fetal prognosis.

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