



Figure 1. Beefy-red, smooth, shiny patch, with well-defined borders and moderate exudation.

application of mupirocine, with complete resolution of the lesion in a week.

The differential diagnosis of intertriginous dermatitis occurring in neonates includes many different entities: irritant contact dermatitis is probably the most frequently found and very often becomes overinfected by *C. albicans*, leading to a candidal intertrigo. Other common forms are seborrheic dermatitis and atopic eczema but more rare diseases may also involve the folds (1,2).

Streptococcal intertrigo caused by GABHS is a peculiar entity which differs from the other intertriginous dermatitises in some clinical features, such as a fiery-red, shiny and exudating surface, well-defined borders, absence of satellite lesions, and foul smell. The neck is the most frequent localization but the axillary and inguinal folds may also be involved. Patients with streptococcal intertrigo are usually well but malaise or low-grade fever may be present. The diagnosis is confirmed by the microscopic examination of material drawn from the lesions, which demonstrates the absence of fungi, and by

microbiological cultures, which identify GABHS infection.

A 10-day oral and topical antibiotic cycle is effective. An erythematous dermatitis may be present after therapy is stopped and probably is related to an underlying dermatitis. Mild corticosteroid creams or other antiinflammatory creams, eventually in association with zinc oxide creams, may be prescribed in such instances (1).

The disease is probably misdiagnosed and underestimated, as recently reported by Honig et al (1), and, although not frequent, should be considered in the differential diagnosis of intertriginous rashes in neonates, especially in unilateral forms with typical features, such as in patients not responding to proper therapy for a candidal or a frictional intertrigo.

REFERENCES

1. Honig PJ, Frieden IJ, Kim HJ et al. Streptococcal intertrigo: an underrecognized condition in children. *Pediatrics* 2003;112:1427–1429.
2. Janniger CK, Schwartz RA, Szepietowski JC et al. Intertrigo and common secondary skin infections. *Am Fam Physician* 2005;72:833–838.

IRIA NERI, M.D.
FRANCESCO SAVOIA, M.D.
FEDERICA GIACOMINI, M.D.
ANNALISA PATRIZI, M.D.
Bologna, Italy
e-mail: iria.neri@tin.it

ON ATOPIC AND IDIOPATHIC EXTENSIVE PITYRIASIS ALBA

To the Editor:

We read with interest the case of extensive pityriasis alba (EPA) in a child with atopic dermatitis (AD) reported recently by Sandhu et al (1). In the article, the main differences between classical pityriasis alba (PA) and EPA, a condition described by Zanon in 1983 in nine dark-skinned young adult females from Lebanon (2) are discussed. Although the single skin lesions of EPA do not differ substantially from those of PA, consistent differences are a widespread and symmetric involvement of the skin of the trunk by numerous, round, nonscaly hypomelanotic patches without a preceding inflammatory phase and with a long-lasting duration. Histologic examination shows a decrease of epidermal melanin; spongiosis is absent. Ultrastructural studies suggested that this hypopigmentation resulted primarily from a reduced number of active melanocytes and a decrease in number and size of melanosomes. No atopy nor associated pathologies or familial occurrences have been reported.

In our opinion, the term EPA is a misnomer. No clear evidence exists of a relationship between EPA and classical PA: not only the distribution of the skin lesions, but also the age of occurrence, the sex ratio (female preponderance), the lack of a preceding inflammatory phase and the absence of spongiosis sharply differentiate the two conditions. In addition, PA usually presents with skin patches showing a slight overlying scaliness and elevated borders. Seasonal variation with exacerbation in the summer and the winter are common. Skin lesions are often located on the face, although involvement of the arms and shoulders is possible. Widespread lesions of classical PA can be observed in atopic dermatitis, but they should not be confused with the disorder described by Zaynoun (2). Current knowledge would lead us to suggest that EPA overlaps with another condition described by Guillet in 1988 as "Progressive and Extensive Hypomelanosis" in persons of mixed racial background (3) and reported also as "Progressive and confluent hypomelanosis of the melanodermic metis" or "Creole Dyschromia" (4–6). This is a primary, acquired hypopigmentation observed in females from 18 to 25 years of age of mixed ethnic origin and characterized by hypochromic, non-scaly macules developing on the back and abdomen, increasing in number and progressively coalescing over the whole trunk into larger patches surrounded by smaller well-defined macules. The resulting hypomelanosis is most apparent in dark-skinned individuals. Comparison between this condition and EPA does not show any substantial differences regarding age and sex distribution, seasonality (summer end), and skin phototype of the affected patients (III–V). The clinical manifestations of these two hypomelanotic disorders are quite indistinguishable and the persistent evolution with poor response to therapy is common to both. Nevertheless a decrease of epidermal melanin is the same histologic change, while a reduced melanosome size can be found on ultrastructural examination of affected areas in both conditions (2,3).

Recently, we observed five female patients with high skin phototype affected by relapsing, hypochromic, nonscaly macules occurring after the summer on the back and spreading over widespread areas of skin. The clinical and histologic features were consistent with the diagnosis of both these entities. Details of these patients are published elsewhere (7).

In conclusion, we think that the condition described by Zaynoun (2) under the name of EPA is a distinct disorder, which cannot be considered an uncommon variant of PA. The latter can occur with multiple and diffuse skin lesions in atopic dermatitis, as in the patient described by Sandhu et al (1). From this point of view their observation that the morphology of EPA lesions

may not be different from that of classical PA is correct. The denomination of EPA suggested by Zaynoun (2) is a misnomer which can create confusion. It is a condition not related to atopy, occurring in young adult females, with a chronic course. To avoid misunderstanding, it should be regarded and identified possibly as "Progressive and Extensive Hypomelanosis," which is a different descriptive term defining the same disease.

REFERENCES

1. Sandhu K, Handa S, Kanwar AJ. Extensive pityriasis alba in a child with atopic dermatitis. *Pediatr Dermatol* 2004;21:275–276.
2. Zaynoun ST, Aftimos BG, Tenekjian KK et al. Extensive pityriasis alba: a histological histochemical and ultrastructural study. *Br J Dermatol* 1983;108:83–90.
3. Guillet G, Helenon R, Gauthier Y et al. Progressive macular hypomelanosis of the trunk: primary acquired hypopigmentation. *J Cutan Pathol* 1988;15:286–289.
4. Guillet G, Hélénon R, Guillet MH et al. Hypomélanoise maculeuse confluyente et progressive du métis mélanoderme. *Ann Dermatol Venerol* 1992;119:19–24.
5. Guillet G, Guillet MH. Dyschromie créole ou hypomélanoise idiopathique du métis mélanoderme de Guillet-Hélénon. *Bull Soc Pathol Exot* 1997;90:333–334.
6. Leseur A, Garcia-Granel V, Hélénon R et al. Hypomélanoise maculeuse confluyente et progressive du métis mélanoderme: étude épidémiologique sur 511 sujets. *Ann Dermatol Venerol* 1994;121:880–883.
7. Di Lerna V, Ricci C. Progressive and extensive hypomelanosis and extensive pityriasis alba: same disease, different names? *J Eur Acad Dermatol Venerol* 2005;19:370–372.

VITO DI LERNIA, M.D.
CINZIA RICCI, M.D.
Reggio Emilia, Italy
e-mail: vito.dilernia@asmn.re.it

CUTANEOUS MANIFESTATIONS OF SEIZURE DISORDER IN CHILDREN—A STUDY OF 100 SEIZURE PATIENTS

To the Editors:

Cutaneous lesions and the findings related to the central nervous system are frequently seen concomitantly in many patients (1). The special bond between the skin and the nervous system has been thought to be their common ectodermal origin (1). We herein report our cumulative experience of cutaneous manifestations observed in 100 consecutive patients (age 0–15 years; 56 boys/44 girls) with idiopathic epilepsy attending the neurology clinic of Kalawati Saran Children's hospital. Of 100 seizure patients 9 (9%) were in age group 0 to 1 years, 29 (29%) in age group > 1 to 5 years, 55 (55%)