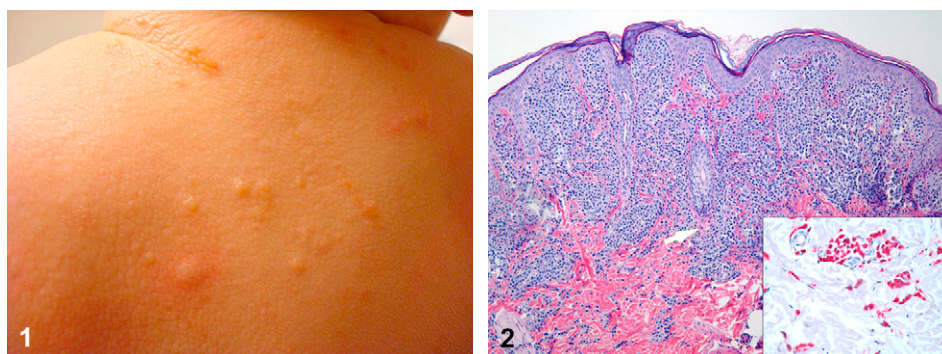


An infant with persistent bullous urticaria

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A 6-month-old male presents with persistent urticaria that has been present since 1 month of age and that began after starting a course of oral ranitidine. The physical examination reveals striking dermatographism and numerous wheals on his trunk and extremities, some with superimposed vesicles and bullae. The distribution of lesions coincides with areas of friction, rubbing, and/or scratching, and the skin appears otherwise normal. Radioallergosorbent testing is negative for common food allergens, a complete blood cell count is normal, and the serum tryptase level is 112 $\mu\text{g/L}$ (normal range, 0.4–10.9 $\mu\text{g/L}$). At 10 months of age, he develops a cobblestoned, doughy pattern on his upper extremities and trunk (Fig 1). A 3-mm punch biopsy specimen is obtained and is stained with hematoxylin–eosin and Leder stains (Fig 2; *inset*, Leder stain).

- What is the most likely diagnosis?
 - Chronic urticaria
 - Diffuse cutaneous mastocytosis
 - Cimicosis
 - Telangiectasia macularis eruptiva perstans
 - Contact urticaria
- Aside from antihistamines, which medication should be considered for this patient?
 - Nonsteroidal antiinflammatory drugs
 - Granulocyte colony-stimulating factor
 - Polyethylene glycol
 - Subcutaneous epinephrine
 - Polymyxin B

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3. In addition to a clinical examination for hepatosplenomegaly, lymphadenopathy, and bone pain, which laboratory test is most helpful in the routine assessment for systemic involvement?
- A. Skeletal survey
 - B. Endoscopy
 - C. Abdominal ultrasound
 - D. Serum histamine
 - E. Complete blood cell count with differential

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