Unilateral Laterothoracic Exanthema

A 10-year-old Caucasian boy was referred for evaluation of an acute eruption that had developed over the past 8 days. The eruption began in the right popliteal fossa, and then coalesced and spread along the right side of his body. A fever of up to 38°C and joint pain were reported 3 days before the appearance of skin lesions. Physical examination showed erythematous and edematous macules and papules on his right hemibody (Figure). The left hemibody did not show any skin lesions. Laboratory testing showed IgM positivity for parvovirus B19. Unilateral laterothoracic exanthema was diagnosed. Oral antihistamine (loratadine 10 mL/day) and emollients were prescribed. Follow-up at 8 weeks showed complete resolution of symptoms.

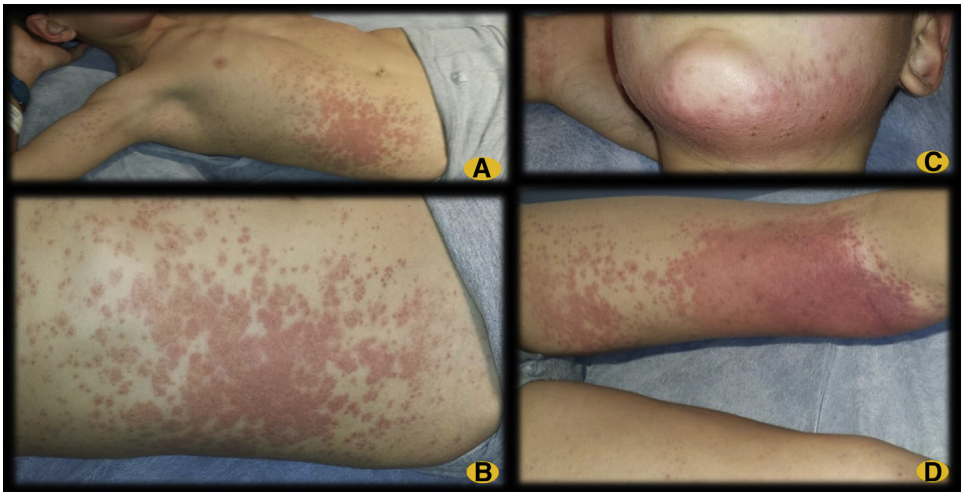

Figure. **A**, **B**, Erythematous-edematous eruption involving the right abdomen side. **C**, Submental area. **D**, Right popliteal fossa.

Unilateral laterothoracic exanthema is an eruption that typically starts around the axilla or popliteal hollow.[1] There is no left or right dominance. It usually spreads along the affected hemibody, and the lesions coalesce to form large erythematous-edematous plaques. The eruption often becomes more generalized, but always maintains a unilateral predominance. Usually, itching is the predominant symptom. Unilateral laterothoracic exanthema is a self-limited process lasting 3-6 weeks. The diagnosis is fundamentally clinical, because it does not require a skin biopsy. Serologic study is usually negative, although there are authors who postulate a relationship between viral infection and rash, such as parvovirus B19 or influenza virus, among others.[2,3] The main differential diagnosis is Gianotti-Crosti syndrome, although this syndrome is usually symmetrical, and the face and extremities being the area's most commonly affected. Oral antihistamines and soothing lotions are the first treatment recommendation. ■

Francisco J. Navarro-Triviño, MD
Department of Contact Eczema and Immunoallergic Diseases
Dermatology
Hospital Universitario San Cecilio
Granada, Spain

Israel Pérez-López, MD
Department of Pediatric Dermatology
Dermatology
Hospital Universitario San Cecilio
Granada, Spain

Ricardo Ruiz-Villaverde, PhD
Department of Dermatology
Hospital Universitario San Cecilio
Granada, Spain

The authors declare no conflicts of interest.

J Pediatr 2021;229:306-7.
0022-3476/$ - see front matter.
https://doi.org/10.1016/j.jpeds.2020.09.033

References

1. Mendelsohn SS, Verbov JL. Asymmetric periflexural exanthem of childhood. Clin Exp Dermatol 1994;19:421.
2. Guimerá-Martínn-Neda F, Fagundo E, Rodríguez F, Cabrera R, Sánchez R, García M, et al. Asymmetric periflexural exanthem of childhood: report of two cases with parvovirus B19. J Eur Acad Dermatol Venereol 2006;20:461-2.
3. Cohen-Sors R, Dadban A, Pezron J, Lok C. Asymmetric periflexural exanthem of childhood and influenza virus infection. Dermatol Online J 2020;26:13030.

Osteochondrosis of Ischiopubic Synchondrosis: Van Neck–Odelberg Disease

A 14-year-old boy was evaluated in the pediatric rheumatology clinic for recurrent gluteal and perineal pain persisting for 1 year. He described an uncomfortable pain that persisted throughout the day and sometimes resulted in restriction of physical activity. He reported no trauma or disease. Physical examination revealed normal height and weight for his age and sex, and puberty consistent with Tanner stage IV. He complained of a stinging pain when pressure was applied to the right groin and to the right side of the perineum. The remainder of the musculoskeletal and systemic examinations were normal.

Laboratory tests revealed normal complete blood count, blood peripheral smear, C-reactive protein, erythrocyte sedimentation rate, anti-streptolysin O test, calcium, phosphorus, alkaline phosphatase, 25-hydroxy vitamin D and parathyroid hormone, and urinalysis. Anti-nuclear antibody, HLA-B27, anti-citrullinated peptide antibodies, and rheumatoid factor were negative.

Abdominal ultrasound examination was normal. An expansion of the right ischiopubic synchondrosis was noted on an anteroposterior radiograph of the pelvis (**Figure**, A). His epiphyses were open. Pelvic magnetic resonance imaging (MRI) revealed a transverse hypointense fibrous band surrounded with edema in the region of the right ischiopubic synchondrosis seen at low signal intensity on T1-weighted MRI (**Figure**, B).

Based on the clinical and laboratory data, the patient was diagnosed with asymmetric hyperostosis and enlargement of ischiopubic synchondrosis (IPS), known as van Neck–Odelberg disease. Clinical symptoms disappeared after a 3-week course of nonsteroidal anti-inflammatory treatment (ibuprofen 30 mg/kg/day) and bed rest. After 3 years, control MRI of the same area showed normal findings.

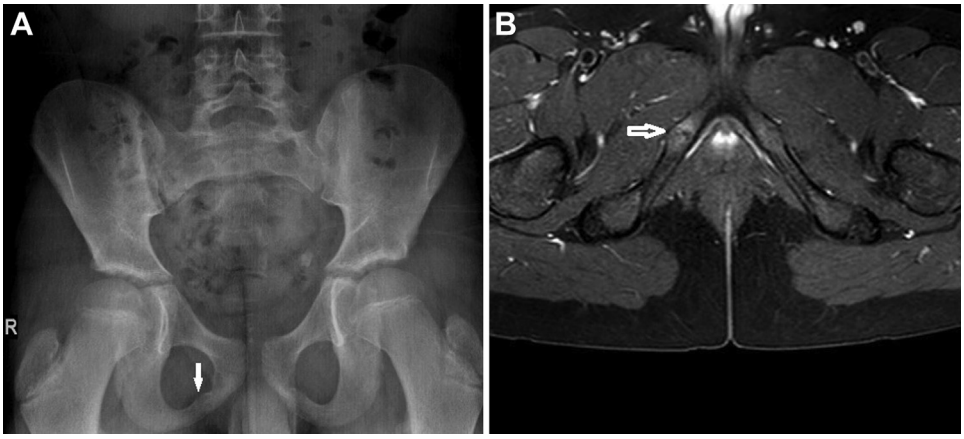

Figure. **A**, *Arrow* shows an expansion of the right IPS on an anteroposterior plain film of the pelvis. **B**, *Arrow* shows transverse hypointense fibrous band surrounded by edema in the region of the right IPS, with low signal intensity on axial proton density–weighted spectral attenuated inversion recovery MRI.

IPS is a tissue line formed from hyaline cartilage between the inferior ischial and pubic rami ossification centers. The ischiopubic area begins to form at the fifth and sixth months of fetal life, and cartilage fusion is complete at the end of a 9-month pregnancy. Ossification of cartilage tissue is completed in the pubertal period. Before ossification, asymmetric expansion of IPS may develop owing to asymmetric mechanical stress on the pelvis. Consequently, an inflammatory reaction causes a delay in widening and ossification.[1] Some children may develop limping and groin and gluteal

J Pediatr 2021;229:307-8.

https://doi.org/10.1016/j.jpeds.2020.09.027