n a daily basis, we pediatricians encounter a multitude of rashes of varied appearance in children of all ages. Most of us gently-seasoned clinicians have seen nearly all versions of these “typical” rashes. Yet, I venture to guess that many practitioners, who would be in good company with some of my quite erudite partners (whom I asked), would not be readily able to identify this relatively newly described truncal rash shown in some of the following cases. As is typical, certain clues are critical, including the child’s age, the duration and the distribution of the rash. Several of these rashes notably mimic more common etiologies, as discussed in some of the following cases. Making an accurate diagnosis of these particularly persistent truncal rashes can readily assuage the frustrated parent.

CASES

Case 1
A previously healthy, afebrile, fully vaccinated 22-month-old white male presents to your office with this now generalized and spreading, primarily truncal rash (see Figure 1). The mildly pruritic rash initially began on the right side of his trunk (see Figure 1A) and then extended distally down to his right upper thigh (see Figure 1B). Although the rash is now distributed over most of his back (see Figure 1C), it is most confluent and most dense over his right lateral ribs.

Figure 1. Afebrile 22-month-old white male presents to your office with this slowly spreading, somewhat generalized, and refractory truncal rash for the past 4 weeks. It initially started on the right side of his trunk (A) and later extended down his right upper thigh (B). The rash has now spread to the contralateral side on his back (C), and is most confluent and thickest over his right lateral ribs.
Healthy Baby

Case 1

A healthy 2-year-old white female who presented with a mostly unilateral, lichenoid, pruritic rash on the left lateral trunk for 3 weeks. Previous treatment with steroid ointments for presumed poison ivy as diagnosed by another physician, has not ameliorated the condition at all, and in fact, the rash is now spreading. The rash also has some petechiae in the axilla and in the lateral rib areas (see arrows), which you presume are due to excoriation. She has been outdoors for many days during the summer, but denies any tick bites or recent medications other than diphenhydramine for pruritus.

Case 2

A previously healthy afebrile 6-year-old white female who presented with a mostly unilateral rash on the lateral abdomen, ribs, and back for 2 weeks. The rash was pruritic, non-tender and unresponsive to steroid creams and two separate previous physician office visits.

Case 3

A previously healthy afebrile 6-year-old white female who presented with an abrupt onset rash spreading over 2 days. It is a fairly heavy crop of ovoid, round and linear pruritic eczematoid-looking lesions distributed mostly on her right trunk and arm regions. This is her first time ever diagnosed with “eczema.” Her previous treatments from an earlier physician visit have consisted of hydrocortisone valerate 0.2% ointment, emollients, and diphenhydramine. However, something peculiar about the appearance and history of the rash sends alarm bells to your cerebral cortex. But she is too young to have that type of rash?

Case 4

A healthy 8-month-old white female who is fully vaccinated and afebrile presents with an abrupt onset rash spreading over 2 days. It is a fairly heavy crop of ovoid, round and linear pruritic eczematoid-looking lesions distributed mostly on her right trunk and arm regions. This is her first time ever diagnosed with “eczema.” Her previous treatments from an earlier physician visit have consisted of hydrocortisone valerate 0.2% ointment, emollients, and diphenhydramine. However, something peculiar about the appearance and history of the rash sends alarm bells to your cerebral cortex. But she is too young to have that type of rash?
Healthy Baby

but not on his back, legs or face. What additional examination should be undertaken, and how should you proceed?

Case 6

You are seeing this 2-year-old white female during the summer for these very discreet isolated but quite pruritic maculopapules on both of her sides and a few on her upper thighs for the last 24 hours. She is afebrile, fully vaccinated, and has been playing outside or swimming most days this summer. When you mention the words “insect bites” during this Saturday morning’s visit, the mother adamantly states that she always sprays her children with insect repellent whenever they proceed outside, particularly the DEET 24% family version. She had read about DEET in Consumer Reports magazine as being the only effective insect repellent. What additional history might have been important to know when trying to identify the etiology?

Case 7

A 4-year-old white female has developed a fever to 100.5°F, headache, and this pruritic truncal morbilliform rash for 3 days. She denies recent travel, tick bites, sore throat, diarrhea, or joint aches. During your examination you notice the flushed cheeks immediately, along with the reticular morbilliform rash localized mostly on the bilateral anterior trunk and upper extremities (see Figure 7, page 314). Once you presume the correct diagnosis, you must warn the family that the rash may persist for a few weeks — so that they do not get frustrated — and that treatment is merely for the symptoms. They also have a teenage daughter who has never had this type of rash.

DISCUSSION

Cases 1, 2 and 3

Each of these three children presented with a rash history, pattern and distribution consistent with “unilateral latero-thoracic exanthem” (ULE), otherwise known as “asymmetric periflexural exanthem” of childhood. However, if you do not recognize these terms, do not be alarmed. The most recent edition of the Nelson Textbook of Pediatrics (19th edition) still does not include this disorder in my search of its index. In each of these patients, the rash began on the lateral trunk area, and then later spread distally or across the midline over a few weeks. The first series of children with ULE was described by Bodemer and de Prost in 1992. ULE is depicted in the Hurwitz Pediatric Clinical Dermatology textbook, 3rd edition as most commonly occurring in children between ages 1 and 5 years. The lesions begin on the lateral trunk area and then may spread centrifugally up to the axilla or inguinal area or posteriorly in up to 50% of children. The lesions often display as maculo-papules, eczematoid, lichenified, morbilliform, or even scarlatiniform and reticular morphologies. Half of children have pruritus, and desquamation is common as the rash resolves. Occasionally the patient may have some low-grade constitutional symptoms, just as with any other low-grade viral infection.

In general, most experts postulate that this illness is likely caused by a host of multiple viral etiologies. Some have speculated that it may occasionally evolve into the papular acrodermatitis of childhood (Gianotti-Crosti syndrome, which I presented in the July 2013 Pediatric Annals issue), and may be caused by those same potential pathogens. One of the critical features of ULE that practitioners must be aware of and must be able to reassure frustrated parents of — the rash usually resolves over 3 to 4 weeks, but it
may last as long as 8 weeks. Treatment is symptomatic only.

Case 4
The 8-month-old female in Figure 4 has typical pityriasis rosea. Ovoid eczematoid “herald” lesion(s) initiated the bilateral truncal rash, along with the almost Christmas-tree-like bilateral pattern on the back. The rash can sometimes be pruritic; constitutional symptoms are uncommon and low grade when they do occur. And again like ULE, the rash may persist for 8 to 12 weeks; its etiology is unknown.

Case 5
Although Group A streptococcal pharyngitis is uncommon in the summer, this young boy in Figure 5 (see page 313) presented with the classic bilateral abdominal truncal rash of scarlet fever. The rash may be pruritic, mostly involves the anterior trunk and axilla, and most importantly on physical examination, it nearly always starts in the groin region. Thus you must always partially pull the pants or underwear down to examine the skin below the pant-line. At 7 to 10 days later, the rash often desquamates in a similar manner as ULE, but only on the hands, feet and groin area, not on the trunk region. A rapid antigen detection test of the throat for Group A strep will nearly always confirm the etiology, except in the rare case of “surgical scarlet fever” caused by Staphylococcus aureus. Treatment is usually with beta-lactam antibiotics, such as amoxicillin.

Case 6
The rash of the afebrile 2-year-old in Figure 6 (see page 313) upon first glance could easily be mistaken for multiple insect bites from chiggers or mosquitoes, especially with her presenting in the first 24 hours of eruption during the swimming season. However, further questioning revealed that the child, although vaccinated against varicella, was exposed earlier for an extended period of time to an aunt with known herpes zoster. About 20% of children who have received a single dose of varicella vaccine will develop breakthrough varicella over a period of 10 years. However, these cases are often “mild and clinically modified,” according to the 2012 AAP Red Book, as in our patient here.

Over the ensuing next few days, some of the lesions crusted over, appeared to be in different stages, and disappeared totally in about 5 days, instead of the usual 7 to 10 days in unvaccinated chickenpox. Therapy can consist of oral acyclovir, or merely symptomatic treatment with anti-pruritics and daily oatmeal baths. An important point to remember is the avoidance of steroid creams or oral steroids when the diagnosis of varicella is considered likely.

Case 7
The truncal rash in our 4-year-old girl from Figure 7 is distinctly different than the previous rashes displayed. It is reticulated, morbilliform, and heavily distributed bilaterally over the abdomen and upper extremities, with none on the back or legs. This is the 2 to 3 week rash of Fifth disease, caused by Parvovirus B19. Although the rash here is not the typical reticular-lacy appearance of Fifth disease, the clinical diagnosis is usually clinched by the appearance of flushed cheeks bilaterally, as seen in Figure 7.

This infection may cause some low-grade fever in 15% to 30% of patients, headaches and other mild constitutional symptoms. It most commonly occurs in the spring. Once infected, immunity seems to be permanent. Importantly, Fifth disease may cause fairly severe articulargias for days to months in more than 50% of older adolescents, particularly females (so warn the sibling). In addition, a potential hemolytic anemia from this infection can be quite dangerous for the fetus in the first two trimesters, and for those with chronic anemia.

CONCLUSION
Clinicians should familiarize themselves with the characteristics of this novel rash (ULE) along with the possible atypical presentations of these other common unique rashes, which are primarily distributed on the trunk. Because many of these rashes may persist for weeks, if misdiagnosed they will become a source of much cost, consternation and frustration for you and the family.

REFERENCES
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