Genital warts are the most frequently observed form of HPV infection and, to date, only 1 double-blind phase II clinical trial has been published on the use of topical cidofovir.9 In that trial, 47% of the 19 patients in the group treated with cidofovir had a complete response with no important side effects reported. This percentage is similar to those obtained with other topical treatments, such as imiquimod and podophyllotoxin.10

This case supports the suggestion that topical cidofovir provides an effective alternative to patients with genital warts resistant to conventional therapies. However, clinical trials are required to determine the efficacy and safety of topical cidofovir in cutaneous lesions caused by HPV.

References

Neonatal Zosteriform Herpes Simplex

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To the Editor:
It is almost impossible to distinguish clinically between the cutaneous lesions of zosteriform herpes simplex caused by the herpes simplex virus (HSV) and those occurring in herpes zoster due to infection with the varicella zoster virus (VZV),1-4 and the distinction is particularly important in neonates, such as the case described in this letter, when correct and early diagnosis and prompt treatment are imperative.1-3 Some of the published cases of neonatal herpes zoster may actually have been HSV infections, since in many cases diagnosis was clinical and the causal virus was not isolated.3,4

We present the case of an 11-day-old full-term newborn infant (gestational age of 40 weeks) admitted to our hospital with a 3-day history of low-grade fever accompanied by umbilicated vesicles and pustules on localized inflamed bases in a metameric configuration on the right-hand side (Figure 1). There were no other previous or concurrent signs or symptoms. The pregnancy and immediate postpartum period had been without incident, and there had been no known contact with cases of chickenpox or zoster. The birth had been by unassisted vaginal delivery. The mother reported having had chickenpox when she was 9 years of age and, when a more detailed clinical history was obtained, reported a history of recurrent vaginal burning and redness indicative of herpetic lesions in the genital area, although none were evident at the time.

The results of blood tests in the infant, including a basic immunologic workup (immunoglobulins and lymphocyte subpopulations), were normal. The results of blood culture
infection and the presence of an revealed histology typical of a herpetic one of the child’s blisters. The biopsy IgM positive) and a punch biopsy of immunoglobulin [Ig] G negative and were the results of serology (HSV-1 were negative. Of particular interest and standard culture of the skin lesions starting treatment with intravenous acyclovir.

Figure 2. Skin lesions 1 week after starting treatment with intravenous acyclovir.

during 15 months of outpatient follow-up. Clinical suspicion of neonatal herpes simplex should be particularly high in the case of assisted delivery or when the mother presents genital lesions consistent with a diagnosis of herpes simplex (and still higher when a peripartum primary genital herpes infection is suspected).

Thirty years ago, more than 85% of cases of neonatal herpes were caused by HSV-2.2 Today, HSV-1 is the cause in almost 50% of cases in immunocompetent young mothers.3 The current incidence of neonatal herpes is estimated to be 15 cases per 100 000 neonates, although many authors consider the disease to be underdiagnosed.2,3 When the medical history is incomplete or the lesions are atypical, is essential.10

Table. Additional Tests Performed

<table>
<thead>
<tr>
<th>Test</th>
<th>Neonate</th>
<th>Mother</th>
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<tbody>
<tr>
<td>Serology for VZV</td>
<td>IgM (–), IgG (–)</td>
<td>IgM (–), IgG (+)</td>
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<tr>
<td>Serology for HSV-1</td>
<td>IgM (+), IgG(–)</td>
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<tr>
<td>Serology for HSV-2</td>
<td>IgM (–), IgG(–)</td>
<td>IgM (–), IgG (–)</td>
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<tr>
<td>PCR in blood</td>
<td>VZV (–), HSV not performed</td>
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<tr>
<td>PCR in skin lesion</td>
<td>HSV-1 (+), HSV-2 (–), VZV (–)</td>
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Abbreviations: HSV, herpes simplex virus; Ig, immunoglobulin; PCR, polymerase chain reaction; VZV, varicella zoster virus.

and standard culture of the skin lesions were negative. Of particular interest were the results of serology (HSV-1 immunoglobulin [Ig] G negative and IgM positive) and a punch biopsy of one of the child’s blisters. The biopsy revealed histology typical of a herpetic infection2 and the presence of an intraepidermal blister caused by keratinocyte necrosis. In the remaining intact keratinocytes, grayish nuclear inclusions with a ground glass appearance were observed together with chromatin margination. A polymerase chain reaction (PCR) assay of a specimen of the biopsy material revealed HSV-1 (Table). These findings established a definitive diagnosis of zosteriform herpes simplex attributed to possible infection in the birth canal.

Treatment was initiated with intravenous acyclovir at a dose of 30 mg/kg/d for 14 days with gradual resolution of the lesions (Figure 2). The patient remained asymptomatic and there was no recurrence of the blisters during 15 months of outpatient follow-up.

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References

3. Villalobos T, McMahon MC, Ratheore MH. Recurrent periorbital zosteriform
Letters to the editor

A Case of Linear Atrophoderma of Moulin

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To the Editor:
Linear atrophoderma of Moulin is characterized by slightly atrophic hyperpigmented patches that follow Blaschko lines. Only a few cases have been reported since the condition was first described by Moulin et al1 in 1992 and most of these have been isolated cases. Moreover, not all of them coincide with the original description. We report the case of a patient with typical clinical and histologic findings.

A 17-year-old male patient presented with hyperpigmented lesions on the right upper arm. The lesions, which had appeared 12 months earlier, occurred as multiple brown macules that formed a distinctive S-shaped curve along the affected arm. Since their onset, they had spread slowly and progressively, grown in number and size, darkened, and acquired a slightly atrophic texture (Figure 1). There were no subjective or objective symptoms, related events, or inflammatory reactions in the affected area. The 2 skin biopsies performed revealed only localized hyperpigmentation in the basal layer of the epidermis (Figure 2). The results of the other tests performed (complete blood count, coagulation, liver and kidney function, antinuclear antibodies, protein profile, erythrocyte sedimentation rate, chest radiograph, and serological tests for Borrelia) were all normal. No specific treatment was prescribed and, with the exception of the darkening of the atrophic patches, the condition remained unchanged during the first 6 months of follow-up. Four years later, the lesions seem to be stable and there have been no evident changes.

Linear atrophoderma of Moulin is a rare skin condition featuring lesions that follow Blaschko lines.1,2 In our review of the literature, we found 22 publications describing the condition (Table). Because several of the clinical and histologic features described do not adhere strictly to the original description provided by Moulin et al,1 the true number of cases may actually be smaller.

References


Figure 1. A, Multiple brown macules following Blaschko lines on upper arm. B, Close-up of the slightly atrophic appearance of the hyperpigmented lesions.