Dermatophile

Acneiform eruptions

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Answers to the following questions can be found on page 160.

Question 1

Case 1: A 3-week-old infant presents with multiple pustules on his face. Lesions have been present for 1 week and do not appear to bother the infant. The child was born via uncomplicated vaginal delivery at 39 weeks. The mother did not receive prenatal care until 22 weeks of pregnancy, when she realised she was pregnant. She is worried that her child might have ‘caught something’ from a sick sibling at home. On physical examination, the child is well appearing, but there are multiple pustules distributed on the forehead, nose and bilateral cheeks (figure 1). What is the diagnosis?

**Question 2**

*Case 2:* A 7-year-old boy presents with complaints of a rash on his chin, cheeks and nose. These lesions initially started around his mouth 2 months ago. His mother thought that they were related to eczema and applied topical triamcinolone 0.1% cream to the lesions. At first, the rash improved. However, it soon recurred and has since spread to involve his cheeks and nose. The child does not seem to be bothered by the lesions other than occasional pruritus and is otherwise very healthy. On physical examination, there are monomorphic erythematous papules on the bilateral cheeks, nose and perioral area (figure 2). What is the diagnosis?

**Question 3**

*Case 3:* A 14-year-old girl presents with complaints of multiple papules on her nose and cheeks, present for years. For the past 6 weeks, she has tried using various over-the-counter acne washes, as well as prescription acne products without improvement. Her current medications include benzoyl peroxide 10% wash, tretinoin 0.025% cream and topical clindamycin 1% lotion. Her parents deny any medical or surgical history and she is in otherwise good health. The patient declines a full-body skin examination. On focused examination of the face, there are multiple erythematous papules on her nose and bilateral cheeks (figure 3). What is the diagnosis?

Select one best answer from the following:

A. Eczema  
B. Periorificial dermatitis  
C. Acne vulgaris  
D. Acne neonatorum  
E. Contact dermatitis  
F. Molluscum contagiosum  
G. Angiofibromas

**Footnotes**

**Contributors** KCL was involved in drafting the manuscript, and PAL revised and supervised the manuscript.

**Competing interests** None.

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**Related articles**
Dermatophile

Answers to Dermatophile questions

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Answers to dermatophile questions

From the questions on page 126.

Answer to Question 1

The answer is (D), acne neonatorum. This, perhaps more accurately called neonatal cephalic pustulosis, is a benign condition that typically presents shortly after birth and resolves within the first 1–2 months of life. Infants present with acneiform papules and pustules, frequently located on the cheeks and forehead and sometimes on the chest. Neonatal cephalic pustulosis lacks the comedones of acne vulgaris. Malassezia furfur or M sympodialis colonisation may play a role in the aetiology of this condition, and the treatment consists of watchful waiting or, if necessary, topical antifungal creams.1
**Answer to Question 2**

The answer is (B), periorificial dermatitis. This, also known as perioral dermatitis, is a common benign condition that can occur in children or adults. Classically, lesions appear as skin coloured-erythematous monomorphic papules measuring 1–2 mm. These papules can appear on the perioral region, nose, cheeks and periorcular region. There may be associated scale or redness if the lesions have been irritated. Pustules are not typical of this condition. Patients may complain of mild pruritus, and lesions can be chronic. Known triggers for this disease include chronic topical steroid use, including those that are inhaled via a mask. Oral steroid use in children causing periorifacial dermatitis has also been reported.

Patients with periorificial dermatitis should be advised to stop the use of all steroids if possible, including over-the-counter steroid preparations. Treatment includes metronidazole 0.75% cream twice daily or oral antibiotics from the tetracycline or macrolide class.

**Answer to Question 3**

The answer is (G), angiofibromas. This 14-year-old girl has lesions characteristic of angiofibromas, previously known as ‘adenoma sebaceum’, associated with tuberous sclerosis. Tuberous sclerosis is an autosomal dominant condition with variable penetrance and mutations in the TSC1 or TSC2 genes. The classic triad of tuberous sclerosis includes epilepsy, learning difficulties and angiofibromas. However, this complete triad is present in only a small minority of patients. Other skin-related features of tuberous sclerosis include collagenomas (shagreen patches), periungual fibromas (Koenen tumors), hypopigmented macules (ash-leaf macules), café-au-lait macules and gingival hyperplasia, some of which may be noted in a full-body skin screening.

Angiofibromas are small, skin coloured to yellow–red, translucent papules located symmetrically over the forehead, nose and cheeks. These lesions may initially be misdiagnosed as acne vulgaris but do not respond to conventional acne treatments. Lesions tend to persist and increase in number over time. Lesions can be treated for cosmesis using shave excision, dermabrasion or laser therapy. However, they commonly recur and require repeated treatments. Recently, there have been reports of topical sirolimus as a safe medical alternative for treating these lesions.

**Footnotes**

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**References**


**Related articles**

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