A healthy 2-year-old female presented with a round, non-tender skin lesion on her buttock, its center black and ulcerated, its margins red. It began as a small black spot a week before and subsequently enlarged and ulcerated, without blister formation, reaching the size and shape shown in the Figure.

The patient was afebrile, without systemic signs or symptoms. Her blood tests, including complete blood count (peripheral leukocyte count of $10.3 \times 10^9/L$ with $3 \times 10^9/L$ neutrophils, $6.1 \times 10^9/L$ lymphocytes, $0.9 \times 10^9/L$ monocytes, and $0.3 \times 10^9/L$ eosinophils), C-reactive protein, and erythrocyte sedimentation rate were unremarkable. The child had no history of recent viral illness or prolonged water exposure (eg, whirlpool, pool with protracted wet diaper, bath tub, or bath sponge). She came in contact with horses and chickens at her grandfather’s farm.

Cutaneous anthrax was suggested. A skin-punch biopsy was taken from the lesion and demonstrated fibrin and mixed inflammatory cells with a necrotic area and neutrophils in the connective tissue. The culture revealed *Pseudomonas aeruginosa*. These findings are consistent with a diagnosis of Ecthyma gangrenosum.

Ecthyma gangrenosum is a cutaneous manifestation of severe, invasive infection by *Pseudomonas aeruginosa*, usually seen in immunocompromised and critically ill patients. Very few cases have been seen in healthy children presenting with this lesion. One review of Ecthyma gangrenosum cases in previously healthy children found that most either had previously undetected immunodeficiencies or transient risk factors (including viral infections and antimicrobial treatment) predisposing them to the development of such infection. *Pseudomonas* skin infection are also known to occur in individuals after use of hot-tubs, whirlpools, water slides, and swimming pools. A previous report of two healthy children with invasive *Pseudomonas* infection linked their infection to prolonged bathing.

Current literature recommends prompt treatment with systemic antibiotic therapy, with *Pseudomonas* coverage, once Ecthyma gangrenosum is suspected, based on clinical appearance. If the lesion fails to respond to antimicrobials, surgical debridement may be required. Isolated Ecthyma gangrenosum has an estimated mortality of up to 25%—a rate that is greatly increased by concomitant sepsis.

In our case, spontaneous recovery was observed prior to the pathologic and microbiologic diagnosis, and the lesion completely resolved within 3 weeks without treatment. Two years since presentation, our patient has encountered no immunologic or other health problems.

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