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SWEET'S SYNDROME IN A CHILD

(A Case Report)

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Summary:
An unusual case of Sweet's syndrome occuring in a child is presented.

Introduction

Since Sweet described the distinctive syndrome of obscure etiology in 1964, many cases have been reported from all over the world, including a large series of 18 cases from tropics (Gunawardena et al, 1975). So far only one case has been reported from Africa (Jacyk and Subbuswamy, 1978).

A wide spectrum of manifestations are recognised of which the most characteristic of the syndrome is appearance of sharply marginated dusky red plaques histologically marked by a dense polymorphonuclear leucocytic infiltrate in the dermis without vasculitis. In more than 50 cases that had been so far reported, the disorder was confined to adults and this is the first report in a child.

Case Report

J.T., a two year old female child was brought to the dermatology clinic with a complaint of painful raised plaques on the face. The skin lesions appeared for the first time two weeks earlier and had been rapidly advancing at the edge. Her general health had been unaffected and there had been no illness preceeding the onset of skin lesions.

At the time of examination she had three large plaques on her face, one on the forehead and one on each cheek (Figs. 1 & 2). They were dull red in colour with an uniformly flat and elevated surface and a sharp advancing margin. There was induration and moderate tenderness on palpation. Regional lymphglands were not enlarged and she was afebrile.

Systemic review was essentially normal and she appeared to be in good health but for her skin problem. Routine laboratory investigations were all normal except for a raised E.S.R. of 40mm/1st hour and moderate leucocytosis of 14000/mm^3. Differential count showed 51% neutrophils, 45% lymphocytes and 4% eosinophils.

While awaiting a histological report on the biopsy, she was re-examined after a week and by that time the margins of plaques on face advanced by 2cms all around and also few new plaques appeared on both hands and legs (Fig. 3). Intense dermal infiltrate of polymorphonuclear leukocytes without vasculitis was the only significant feature in the biopsy. Sweet's syndrome was diagnosed on characteristic appearance of the lesions and the histological features. She was given 15mg of prednisone orally every day and there was prompt resolution of the lesions without atrophy within two weeks. Prednisone was completely withdrawn after four weeks.

Discussion

Several variations from the original syndrome described in 1964 have been brought to light in the subsequent reports (Sweet, 1964; Whittle et al, 1964; Gunawardena et al. 1975; and Jacyk and Subbuswamy, 1978). Most notable in some cases are, absence of fever, male patients, wider clinical spectrum with involvement of eyes, joints and kidneys, recurrences and spontaneous resolution without the use of corticosteroids. Our case is the first report of this syndrome occuring in a young child which also presented in a mild form with only skin lesions unassociated with fever. It appears that greater awareness of the variability of clinical spectrum might show more common occurence of this interesting syndrome.

References

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Continued on Page 93

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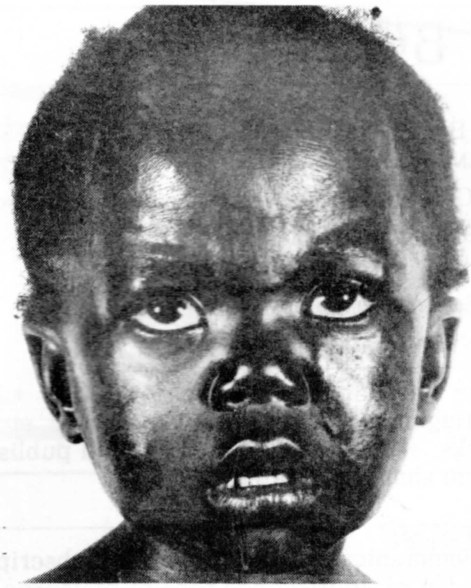

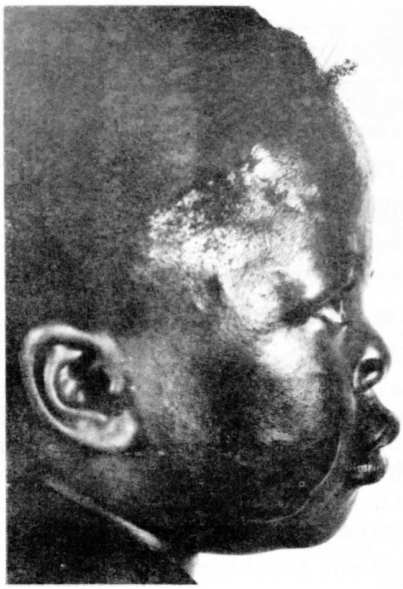

Figures 1 & 2: Sweet's Syndrome: Sharply demarcated erythematous plaques on the face.

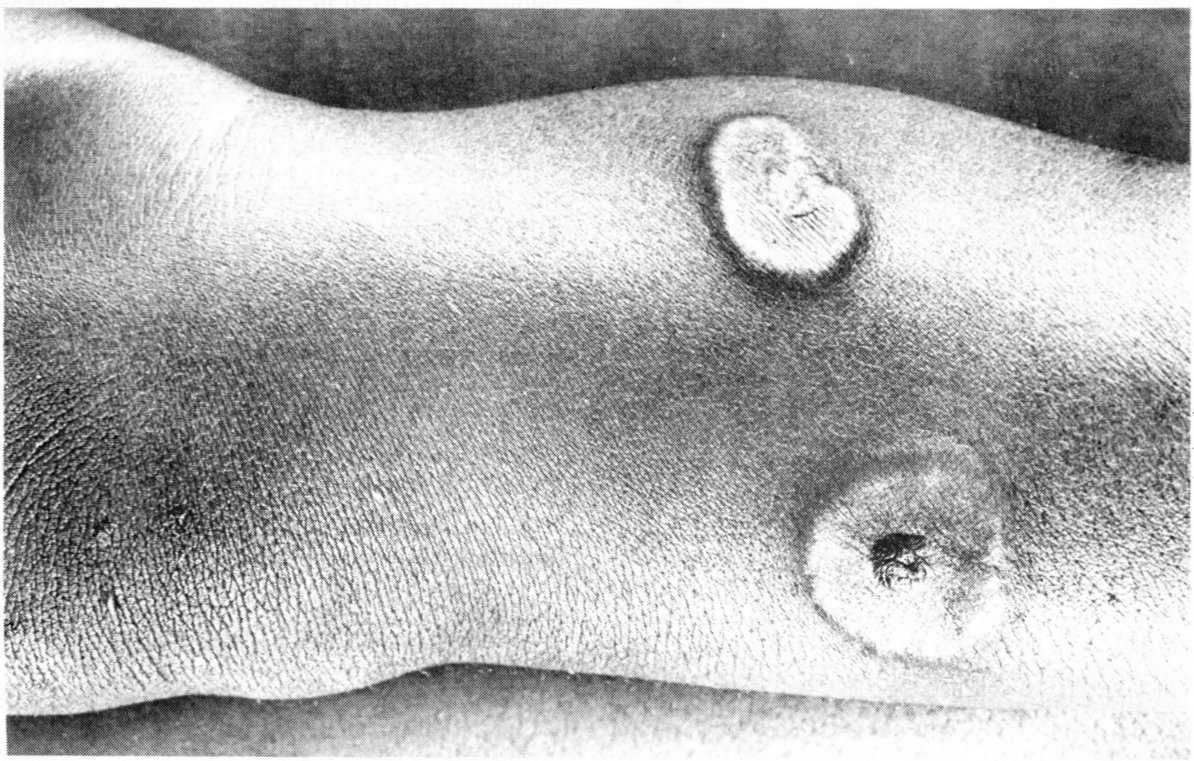

Figure 3: Sweet's Syndrome: Plaques on the leg.

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