Photoclinic: Perianal Streptococcal Dermatitis

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Bhagwan Das Bang, MD, of Opp, Ala, writes that perianal streptococcal dermatitis--originally referred to as perianal streptococcal cellulitis--generally affects children between ages 7 months and 10 years (mean age, about 4 to 5 years). The incidence is consistently higher among boys. Patients may have a pruritic perianal rash, rectal pain with defecation, rectal fissure, and bloody stools. Symptoms may be present for several weeks before presentation.

A small percentage of patients may have concomitant symptomatic or asymptomatic pharyngitis. In these patients, the strain of beta-hemolytic streptococci from the throat often matches that from the perianal region.

The classic rash of perianal streptococcal dermatitis is a superficial, well-marginated, flat, nonindurated, confluent erythema that extends from the anus outward. There are 3 clinical variants:

• A bright pink, moist, tender, erythema, 2 to 4 cm from the anal orifice.
• Minimal perianal erythema associated with painful fissures and a dried, mucoid discharge in the perianal skin.
• A beefy red, psoriasiform eruption that extends several centimeters from the anal skin with yellow, superficial crusting on the peripheral border.

The differential diagnosis includes psoriasis, seborrheic dermatitis, atopic dermatitis, pinworm infection, candidiasis, sexual abuse, and inflammatory bowel disease. Often, medical attention is sought after treatment with an anthelmintic, topical corticosteroid, or antimalarial agent has failed. Culture of the perianal area that grows group A beta-hemolytic streptococci on blood agar confirms the diagnosis. Rapid antigen detection is an alternative diagnostic method.

Perianal streptococcal dermatitis may be associated with vulvovaginitis (the introitus and vaginal mucosa are bright red, edematous, and tender) and with balanitis in uncircumcised boys. Because perianal streptococcal disease may precipitate psoriasis guttata, it is important to examine the genitalia of children with an unexplained flare of psoriasis.

Penicillin is the first-line treatment. In the event of a relapse, erythromycin, a first-generation cephalosporin, clindamycin, or amoxicillin can be used. Adjuvant mupirocin with penicillin treatment may help reduce recurrence. If the patient's symptoms do not resolve with treatment, consider a repeated culture and the possibility of methicillin-resistant Staphylococcus aureus infection. This patient's rash resolved after a week of treatment with penicillin.

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