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CASE REPORT

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Unilateral laterothoracic exanthema in an adult

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Abstract

Unilateral laterothoracic exanthema (ULE) is a benign self-limited condition that spontaneously resolves in a few weeks. Occurring mostly in childhood, although few rare cases in adults have been also reported. Diagnosis of ULE is clinical, and laboratory investigations are not required.

KEYWORDS

adult, asymmetrical periflexural exanthema, childhood, unilateral laterothoracic exanthema

1 | INTRODUCTION

Unilateral laterothoracic exanthema (ULE) is an underrecognized entity. Clinically, it is characterized by a lateral exanthema that starts typically in the axilla. ULE affects mostly children aged between one and five years of age. Its occurrence in adults is uncommon. Herein, we reported a case of ULE in an adult.

Unilateral laterothoracic exanthema (ULE) is a distinctive skin eruption, characterized by a lateral exanthema that often starts in the axilla region and spreads in a centrifugal pattern. It is a benign self-limited condition that resolves spontaneously in a few weeks. ULE affects children aged between one and five years of age. In the literature, a few adult cases have also been reported. Herein, we reported a new adult case.

2 | CASE REPORT

A 30-year-old woman presented with an acute pruritic thoracic exanthema evolving for 4 days. There was a history of malaise and rhinorrhea a few days before the eruption. The rash had begun in her left axilla and spread along her left lateral thoracic wall to her left arm. Physical examination revealed maculopapular erythema involving the left axilla, ipsilateral hemithorax, and slightly extending to the right hemithorax (Figure 1A). Also, the rash involved the medial surface of her left arm and her left foot (Figure 1B). The remaining dermatologic examination was unremarkable including mucosal faces. The patient was afebrile and the remaining physical examination, including lymph nodes, was normal. Our presumptive diagnosis was unilateral laterothoracic exanthema (ULE). Oral antihistamines were prescribed for itching. The lesions resolved spontaneously within 3 weeks (Figure 2).

ULE, also known as asymmetrical periflexural exanthema of childhood or superimposed lateralized exanthem, is an underrecognized condition and is uncommon after childhood. Few cases have been reported in adults.[1] There is usually a prodrome involving the gastrointestinal or respiratory system preceding the exanthema. Regional lymphadenopathy and pruritus are present in approximately 50% of cases.[2]

Clinically, ULE is characterized by a unilateral exanthema. It often starts close to the axillary region and spreads in a centrifugal pattern to the trunk and the medial surface of the arm. The rash may also involve the ipsilateral groin or leg as in our patient.

ULE has been associated with viral infections given its occurrence in children's age, the seasonal onset in late winter and early spring, the frequency of upper respiratory tract prodromes, and the self-limiting course of the disease.[3] Parvovirus B19, parainfluenza virus, and adenovirus have

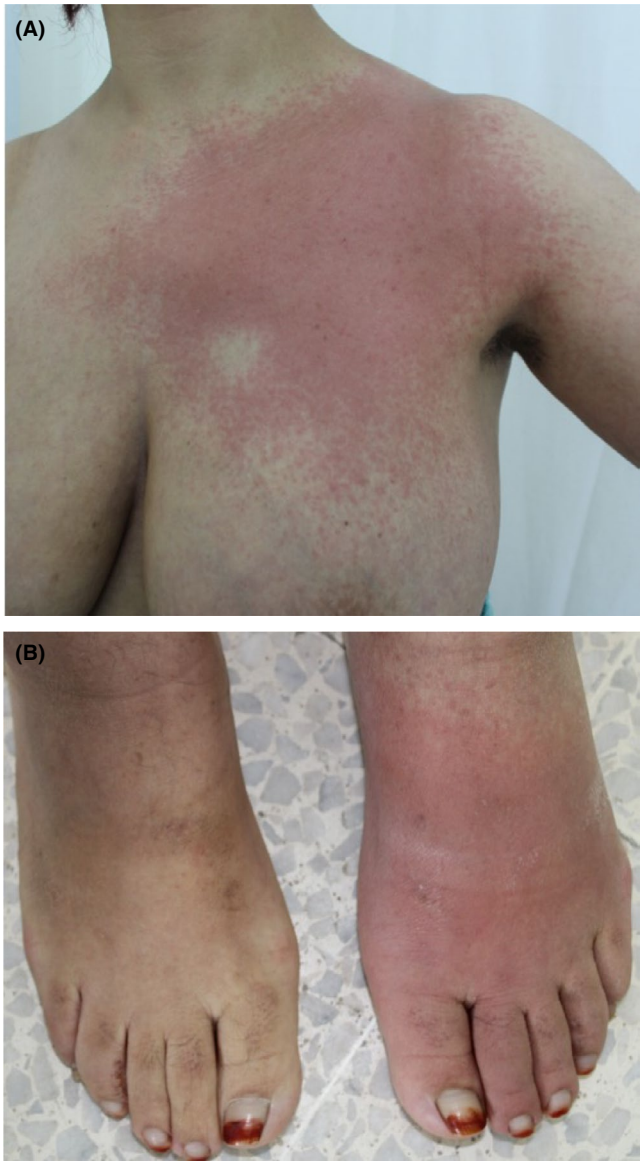

FIGURE 1 A, Maculopapular confluent erythema involving the left axilla, ipsilateral hemithorax, and slightly extending to the right hemithorax. B, Rash involving the dorsal aspect of the left foot

been inconsistently reported in association with this peculiar exanthema.[4] Recently, authors have proposed a new concept that a postzygotic mutation has rendered the keratinocytes on one side of the body more responsive to infectious agents.[3]

The eruption can sometimes reach the contralateral side but a pronounced asymmetry is maintained. This asymmetry would reflect less pronounced reactivity of epidermal cells that do not carry the postzygotic mutation to develop an inflammatory rash.[3,5]

The diagnosis of ULE is clinical. Laboratory investigations and skin biopsy are not required. Histological examination, when performed, shows nonspecific features, such as perivascular lymphocytic infiltrate and lichenoid dermatitis.[4]

Due to limitations in infrastructure, we could not investigate our patient for the virological profile to identify the possible etiological agent. The complete resolution within three weeks further supported the likelihood of viral etiology, most likely being ULE.

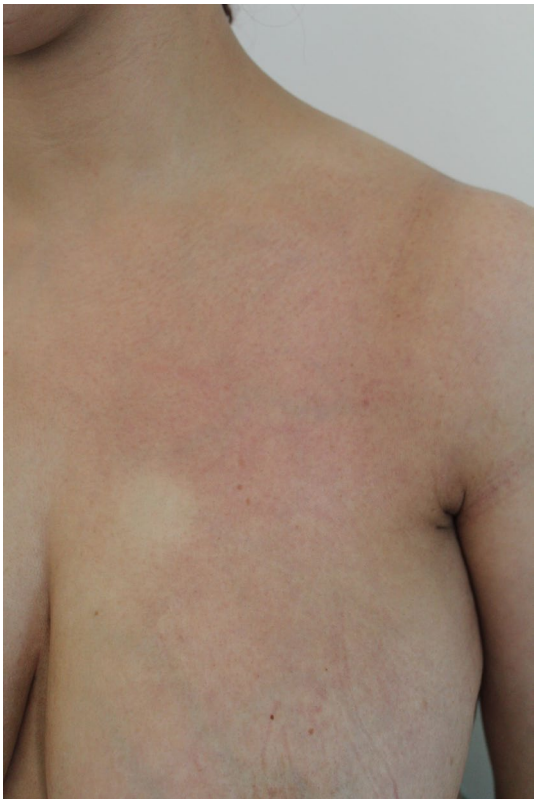

FIGURE 2 Spontaneous resolution of the eruption within 3 wk

In summary, we report a case of ULE occurring in an adult. Knowledge of the self-limiting course of this disease allows physicians to reassure the patient and to avoid unnecessary investigations.

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Published with written consent of the patient.

CONFLICT OF INTEREST

None declared.

AUTHOR CONTRIBUTIONS

Drs Amal Chamli and Asmahene Souissi: contributed to the first draft of the manuscript. Drs Amal Chamli, Asmahene Souissi, and Olfa Midassi: contributed to the literature search, analysis, and interpretation of the data. Dr Mourad Mokni: critically revised the manuscript and gave final approval. All authors: read and approved the final manuscript and agree to be finally accountable for ensuring the integrity of and accuracy of the work.

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