Child Abuse & Neglect 35 (2011) 230–233

Contents lists available at ScienceDirect

Child Abuse & Neglect

Brief Communication

Painful genital ulcers in a 10-year old girl

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ARTICLE INFO

Article history:
Received 10 July 2010
Received in revised form 26 October 2010
Accepted 2 November 2010
Available online 9 April 2011

Keywords:
Pyoderma gangrenosum
Genital ulcers
Genital lesions
Child abuse
Child sexual abuse
Pediatric dermatology

Introduction

Painful genital ulcers in the pediatric population are predominantly infectious in etiology and include HSV, EBV, and VZV (Kellogg & Frasier, 2009). These infections typically begin with vesicular lesions which ulcerate then resolve over time. In contrast, vesicles or blisters are not a feature of pyoderma gangrenosum, and the enlarging central ulcerative base is not typically seen with viral ulcerative conditions. Primary syphilis can produce a larger ulcer but generally is not painful or progressive. Other causes of painless genital ulcers include lichen sclerosus, Crohn's disease, lymphogranuloma venereum, and granuloma inguinale (Kellogg & Frasier).

Non-infectious causes, to also consider, of genital ulcers reported in the pediatric population include Behcet's disease and Reiter's disease. Both are characterized by painful oral and genital ulcers, arthritis, and ocular inflammation and conjunctivitis in Reiter's disease. Because Reiter's disease can follow sexually transmitted infections (STIs) such as chlamydia, as well as non–sexually transmitted infection such as shigella, clinicians should be aware of the possibility of sexual abuse (Eldem, Onur, & Ozen, 1998; Zivony, Nocton, Wortmann, & Esterly, 1998). Other diseases producing multiple painful genital ulcers or necrotic tissue include lichen sclerosus et atrophicus, Stevens–Johnson syndrome, erythema multiforme, folliculitis, impetigo, bullous fixed drug eruption, and Candida (Adler, 1983). Recently the Mayo Clinic has published a series of reactive nonsexually related acute genital ulcers (RNSRAGU) which occur following a viral illness and are usually seen in patients with a history of oral aphthous ulcers (Lehman, Bruce, Wetter, Ferguson, & Rogers, 2010). Table 1 outlines the various causes of vulvar ulcers.

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doi:10.1016/j.chiabu.2010.11.006

Table 1
Various causes of vulvar ulcers.

Diagnosis	Clinical signs	Symptoms	Lab tests
EBV	Painful ulcers	Fever, lymphadenopathy	EBV serology
HSV	Grouped vesicles, painful punched out erosions	Fever when primary, pain/burning	(+) HSV culture
Syphilis	Painless ulcer	Afebrile	(+) RPR, treponemal antibodies
Lichen sclerosus	Atrophic anogenital skin, friable	Pruritus, bleeding	None
Behcet's disease	Recurrent oral and genital ulcers	Malaise, uveitis	Eye exam, pathergy test
RNSRAGU	Shallow ulcers, often with oral ulcers	Follows febrile illness	Biopsy
PG	Deep painful ulcers, purpuric border with undermined appearance	Often seen with IBD, malignancy, or viral illness	Biopsy

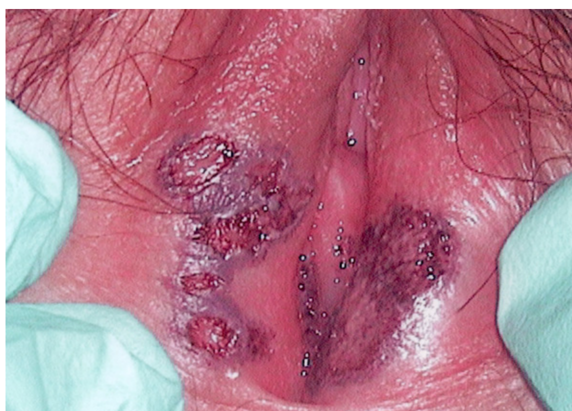

Fig. 1. Purpuric ulcers involving the labia majora.

Case report

A 10-year old premenarchal female presented to a children's emergency department with a 5-day history of genital pain, vomiting, diarrhea, and fever up to 38.9 °C. Abdominal cramping and dysuria began 6 days earlier. Home medication with ibuprofen, acetaminophen, and diphenhydramine hydrochloride provided marginal pain relief. She complained of tender sores along the labia majora that were noted to be progressing in size and discomfort. The patient was evaluated by a sexual assault nurse examiner after a physician suspected possible herpes simplex virus (HSV) infection. The patient consistently denied any sexual contact. Genital examination with a photocolposcope revealed several ulcerations involving the labia majora, vestibule, and hymen (Figs. 1 and 2). Light touch to these areas with a culture swab moistened with sterile water elicited intense pain. After cultures were collected viscous lidocaine was applied for pain control. No ulcers were visualized

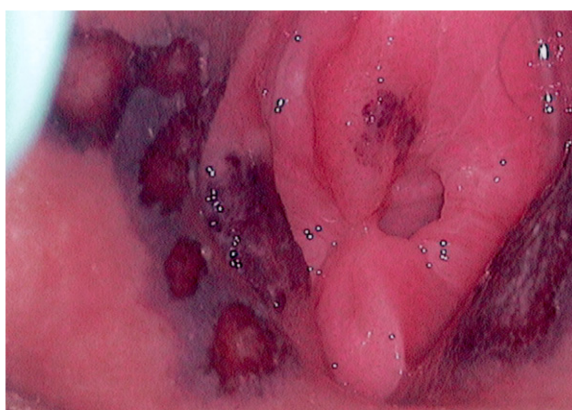

Fig. 2. Ulcers involving the vestibule and hymen.

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