

## Case No Bulloso Impetigo

This article was published in the following Scient Open Access Journal:

Journal of Dental and Oral Health

Received February 16, 2016; Accepted March 09, 2016; Published March 15, 2016

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### Abstract

Impetigo is a superficial skin infection typically presents multiple vesicular lesions on an erythematous base. The condition is common in children aged 2-5 years though it can occur at any age. Factors that predispose infection include skin abrasions, trauma, burns, insect bites, chickenpox, poor hygiene and others. Two types of impetigo are described, non-bullous it represents the most common form and is attributable both streptococcus like this estafilococcus. Bullous or bullous impetigo is less frequent than the last and usually initial areas of minimal trauma are observed. The treatment is done with topical treatments such as fusidic acid and mupirocin, when the disease is extensive oral antibiotics are used.

A clinical case of an infant female, 10 year old who attends the service of pediatric dentistry and orthodontics to present clinically lesions compatible with perioral impetigo, the presumptive diagnosis was based on epidemiology, clinical appearance of the lesions is reported (erythema, mielisericas scabs), although the extent of the infection was only treatment performed topical.

**Keywords:** Microvesicular impetigo, Bullous impetigo, Contagious impetigo

### Introduction

It is one of the most common skin infections in children has special predilection, comes in suddenly with small vesicles purulent with erythematous base, which when broken leave exulceradas areas covered by melicericas crusted yellow, can also be lymphadenopathy and erosive cheilitis [1,2].

The incidence are manifested in preschoolers 2-5 years old, but can occur at any age produced by the S. Aureus phage group usually II [3].

Factors that predispose infection include skin abrasions, trauma, burns, insect bites, chickenpox, poor hygiene and others [4].

There are two clinical forms bullous, bullous or bullous and non ampolloso [5].

### Bullous Impetigo

Always caused by S. Aureus is the result of the action of a toxin epidermolytic. Surface blisters appear smooth walls, transparent content initially and later cloudy. Blister ruptures leaving an erosive surface eritematosa [4]. Number 3-6 Injuries appear limited to one area. They can settle in any area of the body surface, being more often appeared on exposed areas of the face, around the holes in the mouth or nose and limbs.

There is a tendency to spontaneous healing without scar hypopigmentation can leave residual [4-6].

### No Impetigo Bullous (Contagious Micro vesicular)

It represents the most frequent form 70% [5,6].

It usually begins in areas of minimal trauma (insect bites, superficial wounds, chickenpox lesions). Characteristic lesions are small erythematous papules evolve quickly to a thin-walled bladder erythematous base, and rapidly break formed an exudate which dries forming yellow crusts. The lesions often spread giving satellite lesions. You can give adenopatias [6].

### Differential Diagnosis

Herpes simplex Chickenpox blister Ringworm, bullous fixed drug reactions, thermal

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or chemical burns 2nd grado [7-12].

## Forecast and Clinical Evolution

Left untreated invasive infection can complicate impetigo caused by *S. Aureus* with cellulitis, lymphangitis and cause bacteremia and osteomyelitis, septic arthritis, pneumonitis and septicemia. Exfoliatin production can cause staph scalded skin syndrome in kids [8,11,13-15].

## Treatment

Local mupirocin ointment, removing scabs and good hygiene is sufficient to cure most cases. Systemic antibiotics may be useful in cases diseminados [6,11,12,16-18].

1. Good general hygiene and nail cutting.
2. The removal of crusts and use of topical antiseptics has not shown clinical evidence.
3. Topical antimicrobial treatment. There are many preparations but two stand out for their activity and tolerance.
  - a) Fusidic acid
  - b) Copper sulphate {Day 2-3, 7-10 days}
  - c) Mupirocin

They limit the transmission and are the treatment of choice for localized forms. Get high concentrations in the stratum corneum and are not described cross resistance with other antibiotics.

When dealing nasal carriers of *Staphylococcus* preparations should be used that does not contain propylene glycol (irritates the mucous membranes).

4. Systemic antibiotics produce faster healing and prevent deeper suppurative disease

### Directions:

- Forms of impetigo with multiple injuries or major extension
- Locations difficult to treat (perioral areas, folds)
- If there are underlying factors such as atopic dermatitis or diabetes.
- If it affects several family members or school.

They should be prescribed systemic antibiotics effective against *staphylococcus* and *streptococcus*: [4,6,11,12,18-20].

- Cefadroxil, amoxicillin + clavulanate, penicillin or amoxicillin (if streptococcal)
- Cloxacillin (if staphylococcal) or macrolides in case of hypersensitivity to beta-lactams

## Clinical Case Report

Female patient 10 years of apparently healthy, arrives to see continuing dental treatment but this no presence of pain perioral region is performed, referring to present three days, yellowish lesions around the nose does, because then they covered around the mouth, that the words of the patient.

Physical examination shows dermatosis located head, which affects the face and perinasal and perioral region. Consisting of scaly erythematous plaques, covered by melicericas crusts. Hindering the full opening of the oral, acute and painful cavity. The rest of the skin unaltered. He proceeds to measure the temperature with a report of 38.2 degrees celsius.

As described above diagnosing non bullous impetigo, thereby fomentation begins with copper sulfate and twice daily topical mupirocin twice daily is performed.

The day of treatment, an improvement of 80% of the lesions is observed (Figures 1-3).

## Discussion

The pediatric dentist is one of the first to detect this type of skin lesions. In the case reported it is a dentist reporting and makes interconsultation with dermatology indicated to give a diagnosis and ideal treatment.

The non-bullous impetigo is a bacterial skin infection that is seen in all age groups but is most common in preschoolers [21-23].



Figure 1: No buloso Impetigo



Figure 2: No buloso Impetigo



Figure 3: Post-treatment.

Diagnosis and treatment is mainly performed based on clinical criteria.

The etiological agent involved in the non-bullous impetigo is the Staphylococcus and Streptococcus, meliserica crust being the most characteristic finding.

The regional lymphadenopathy, itching and pain are frequent data [24,25].

Impetigo is considered a public health problem in countries developing, with few control advances globally. It has been observed that there is a higher incidence of disease in tropical developing countries; it is for this reason that there has been renewed interest in a global initiative to control this type of skin infections. It is considered as a benign disease, but which can lead to more serious diseases such as the abscess formation, cellulitis and dare local spread bacteremia and sepsis after hematogenous invasion and non- suppurative sequelae glomerulonefritis post-acute streptococcal and possibly acute rheumatic fever [26-29].

## Conclusion

Impetigo is a highly contagious infection and pediatric population is the most vulnerable and that is why timely intervention for diagnosis and treatment is very important to avoid complications from the infection.

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