

two months prior to his presentation to our clinic when he significantly worsened.

On presentation, the patient demonstrated greater than 50% hair loss with a shiny erythematous patch of alopecia affecting his vertex scalp extending to his frontal and parietal scalp. On palpation multiple boggy nodules were present with sinus tracts and drainage of serosanguinous and purulent material. The patient did not exhibit lymphadenopathy but noted scalp tenderness. A 6mm punch biopsy was obtained from the patient's right parietal scalp.

Differential Diagnosis

The differential diagnoses for a boggy, fluctuant mass with significant alopecia includes primary or secondary infection, dissecting cellulitis of the scalp, severe discoid lupus erythematosus (DLE), and a kerion. Dissecting cellulitis of the scalp presents as boggy, fluctuant, suppurative nodules often with purulent drainage and hair loss, however, it occurs predominately in the post-pubertal population making it a much less favored diagnosis for our patient.^{1,2} Severe DLE can present in children with a scalp rash and alopecia but is much more common in adults and women and boggy, fluctuance would be atypical.³ Primary or secondary bacterial infection is considered in the setting of uncertain primary diagnoses of psoriasis and seborrheic dermatitis, as seen in our patient.

Scalp psoriasis occurs commonly in children and presents as a silvery scale and occasionally with alopecia. However, psoriasis is unlikely to be secondarily infected by bacteria due to increased production of anti-microbial peptides.⁴ We also had a low index of suspicion for seborrheic dermatitis due to its bimodal distribution, occurring in infants up to 3 months of age and in adults in the fourth to sixth decade of life.⁵ Irritant or allergic contact dermatitis were considered but the patient's mother endorsed no correlation of symptoms with use of hair care products or other irritants. Our highest index of suspicion was for kerion.

Histology

A 6mm punch biopsy and culture are obtained from the patient's right parietal scalp which reveal the definitive diagnosis.

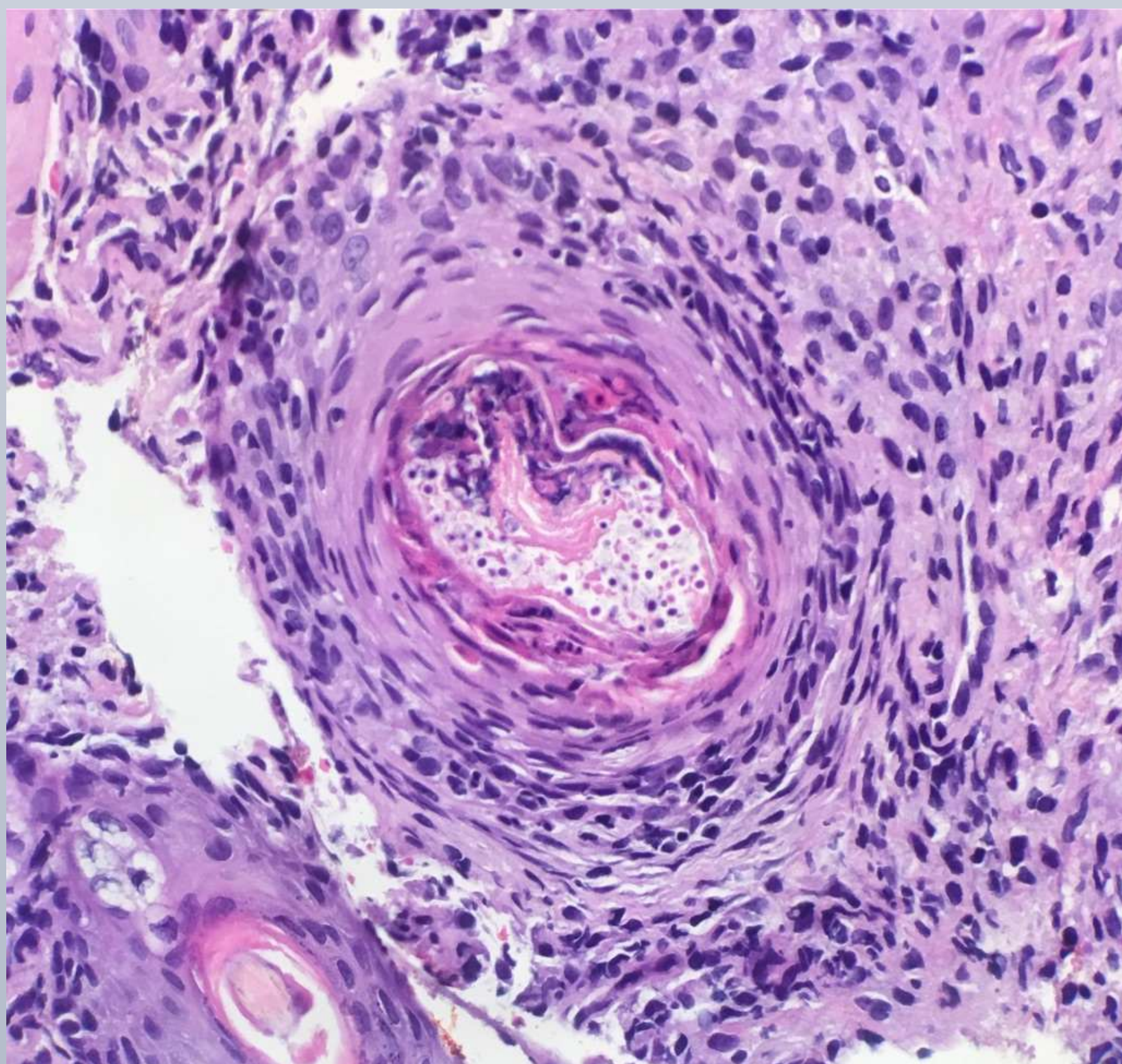


Figure 1: The biopsy revealed many hyphae and spores in the hair shaft bulb with acute, chronic, and focally granulomatous inflammation. Tissue culture identified *T. tonsurans*.



Figure 3: Lateral view of alopecia and focal drainage of serosanguinous and purulent material.



Figure 4: Patient 8 weeks of therapy, with resolution of the boggy, erythematous plaques and some terminal hair regrowth.

With numerous erythematous tender boggy nodules and associated alopecia.

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In any case excluded.⁷ Primary diagnosis. A scaling, alopecia, tineia capitis, adenopathy, adenopathy, positive for this is a finding capitis.

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