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Case Report

Acute Hemorrhagic Edema of Infancy - Finkelstein Seidlmayer Disease

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Abstract

In 1913, Snow described small blood vessel vasculitis, which is now called acute hemorrhagic oedema of infancy (AHEI) or Finkelstein Seidlmayer disease. AHEI is a rare disease with an unknown prevalence.

We report a 11month old girl with a ecchymotic purpura and swelling of both feet and small petechial rashes in both earlobes and face.

Our aim to report the case to say acute hemorrhagic edema of infant is a benign disease with no need for invasive investigations and hospital admission.

Keywords: Hemorrhagic Edema of Infancy, Acute Hemorrhagic Edema of Infancy, AHEI, Finkelstein Seidlmayer disease.

Introduction

There have being reported 18 million new cancer cases worldwide for the year 2020, In 1913, Snow described small blood vessel vasculitis, which is now called acute hemorrhagic oedema of infancy (AHEI) or Finkelstein Seidlmayer disease [1]. AHEI is a rare disease with an unknown prevalence. Most cases are 4-24 months old; 300 cases have been reported to date [2].

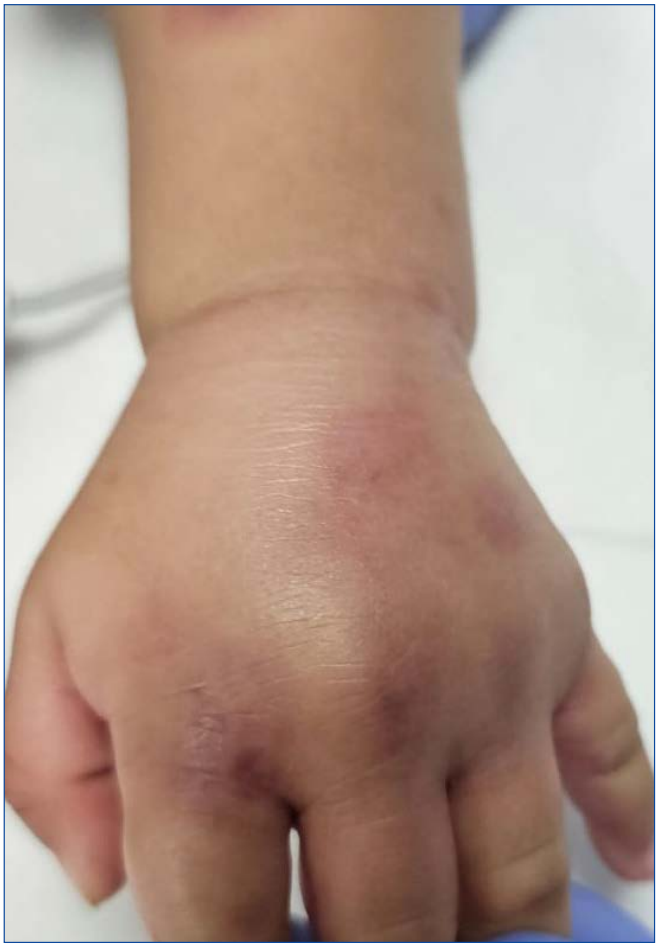
The typical clinical presentation is palpable, nonpruritic, and symmetrically distributed skin lesions. The body's distribution sites are the face, auricles, and extremities. Oedema in AHEI is a nonpitting asymmetrical oedema found primarily on the dorsum of the hands and feet, the face, and the auricles. Despite the wide distribution of the lesions in the extremities, the child looks good and nontoxic. Rarely systemic and/or visceral involvement can be found [3].

Our aim for reporting the case is to highlight that despite its dramatic skin appearance, it's a benign disease.

Case Presentation

An 11-month-old girl was seen in the Pediatric Emergency Department on her third day of complaints, with a history of fever for three days, cough and the sudden appearance of ecchymotic purpura and swelling of both feet and small petechial rashes in both earlobes and face. On the second visit after three days, new lesions appear in the lower legs and forearms. Hematomas lesions and painless non-itching oedema appear in extremities, with necrosis in the centre of some lesions. ***(Fig. 1,2 and 3)***. Small petechial lesions in the buccal mucosa were observed and were not painful with normal feed. A full systemic examination was typical, with normal vital signs, normal weight and height for her age. Full-term baby, normal pregnancy and neonatal period, normal psychomotor development, fully vaccinated—no family history of bleeding tendency or disorder.

Investigations showed normal complete blood count (CBC), haemoglobin level, and number of erythrocytes, platelets and leucocytes. The patient had normal blood coagulation screening (activated partial thromboplastin time (aPTT), and prothrombin time (PT)), increased inflammatory markers (C–reactive protein was 78.37mg/L and erythrocyte sedimentation rate 48mm/H), normal liver and kidney function tests, electrolytes, serum proteins and albumins, and urine analysis. Urine and blood cultures showed no growth. Virology analyses (Epstein Barr IgM was positive, Cytomegalovirus was negative). The throat swab culture showed heavy growth of streptococcus pyogenes group A. Chest and Abdominal X-ray were normal.



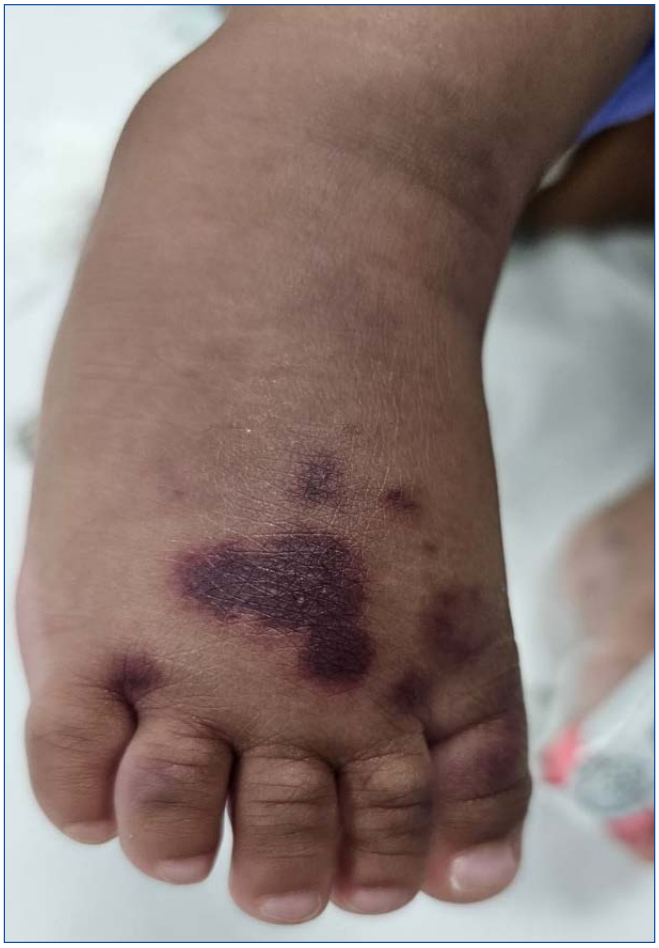


Figure: 1 and 2

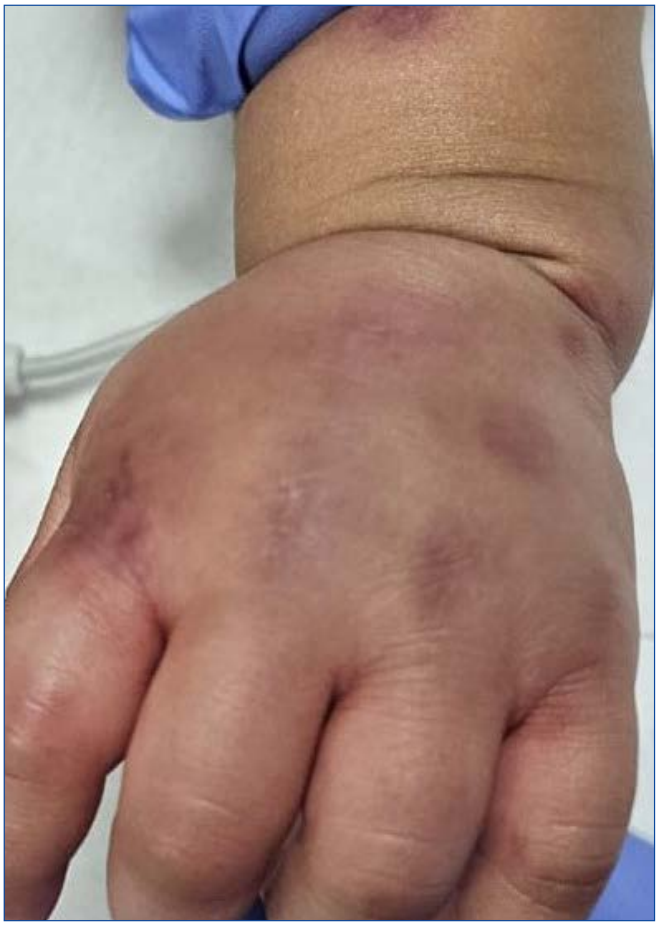


Figure: 3

Discussion

AHEI is reported to be more common with viral or bacterial infections, vaccination, and some drugs. It occurs in all seasons but more in winter, which supports the idea that it is a disease triggered by viral infections or vaccination that leads to cytokine storms [4-6].

Fiordelisi A, et al. in their study, the median age of presentation was 18 months old (7-23 months); most of their case occurred after prodromal symptoms and had typical purpuric skin lesions with oedema [7].

Leducq S, et al. median age was 11 months, purpura and ecchymosis in most of their patient, oedema in 95% of their population study, and few patients in their study had positive infections [8].

Diagnosis of AHEI is usually clinical, and if laboratory investigations done were reassuring in all patients [9,10].

Treatment is supportive, with complete resolution of skin lesions within 1 to 3 weeks; corticosteroids and antihistamines will not change the course of the disease [11,12].

Complications like intussusception, hematuria, proteinuria, hypocomplementemia and skin scaring are rarely reported [13].

Conclusion

In conclusion, this case report shows that acute hemorrhagic oedema is a self-limiting disease with normal laboratory investigation with excellent outcomes.

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