

CHILDHOOD ROSACEA.

A 5-year-old girl presented erythematous lesions of the nose and middle of the face, lasting from 6 months with a waxing and waning clinical course, asymptomatic. Her family history was not contributive for autoimmune disorders. Her personal history showed recurrent chalazia and a recent episode of herpes simplex labialis. On physical examination (Fig. 1) there were dot-like erythema, sometimes merging in patches with blurred outlines, and some telangiectases. The indexes of inflammation and also the examinations aimed at testing the complement factors and the serum and cell-mediated immunity were within normal limits. The fresh examination of scales put in evidence numerous mites of the *Demodex folliculorum* species (Fig. 2). These findings led to diagnose **childhood rosacea**. An ophthalmological consultation ruled out actual pathological manifestations. A local treatment with 0.75% metronidazole gel was prescribed and a pulsed treatment with azitromycin was scheduled in case of failure.



Fig. 1

Rosacea usually affects adults in the third-fifth decade and prevails in females with a 3/1 ratio as compared with males. However, it may also affect children (1, 2, 4). In childhood, rosacea is never responsible for rhinophyma, whereas the eye is often affected, sometimes severely (4). The eye is often involved before the onset of skin lesions with recurrent chalazion, blepharoconjunctivitis, keratitis, episcleritis and uveitis (4). This is why some Authors advise an ophthalmological consultation in all cases of rosacea, especially in children. *Demodex folliculorum* is present mainly in pustular forms (3), but sometimes, as our case shows, even precociously when pustules lack. Its pathogenetic role in rosacea is debated.

Antibiotics are the first-choice **treatment** of rosacea. Tetracycline, which is the most effective systemic antibiotic, cannot be used in the first 8 years of age.

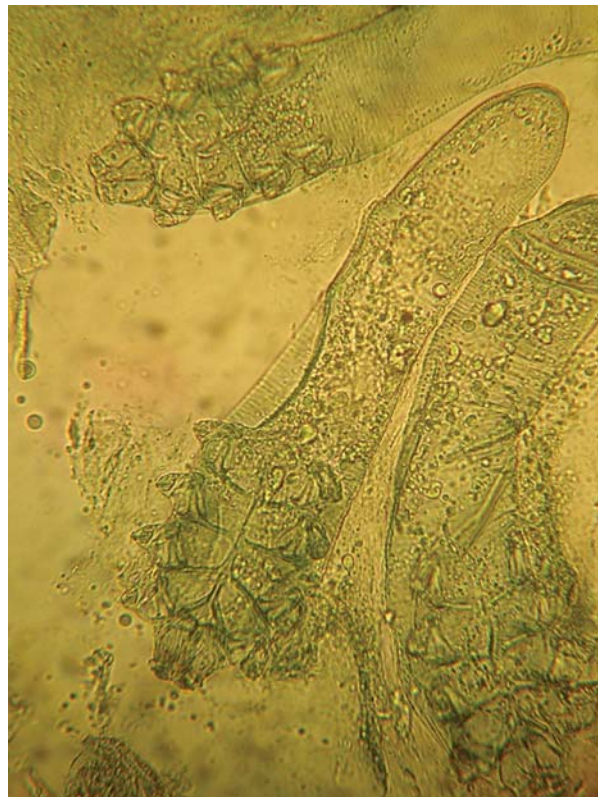


Fig. 2

References

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