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Dermatology

About Two Buttocks: Erysipelas Atypical Location

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Abstract **Case Report**

We report the case of a 58-year-old patient who presented with diaper erysipelas. The diagnosis was essentially clinical. This location remains atypical because it is uncommon, the lower limbs being most often affected. Treatment combines antibiotic therapy, lymphatic drainage and restraint to reduce lymphedema and prevent relapse.

Keywords: Erysipelas, Acute bacterial dermohypodermatitis.

INTRODUCTION

Erysipelas is an acute non-necrotizing dermo-hypodermitis of most often streptococcal origin. In more than 85% of cases, it affects the lower limbs, being favored by the presence of an entry point, most often cutaneous. From an epidemiological point of view, the existence of a portal of entry, lymphedema and obesity are considered to be the main risk factors for occurrence [1]. In the literature, the gluteal location has rarely been described. In this work, we report the case of a woman who presented with bilateral gluteal erysipelas, with the aim of studying the epidemiological, clinical, therapeutic and etiopathogenic particularities of this entity.

OBSERVATION

This is a 59-year-old patient with a history of a similar episode a year ago who presented for a month a painful hot red plaque initially at the level of the left buttock then extending to the right buttock at the left. clinical examination we note the presence of a warm painful erythematous edematous plaque poorly limited, discontinuous, with irregular contours, indurated in places, located at the level of the buttocks extending bilaterally on either side towards the hips with a Bilateral inguinal intertrigo and gluteal intertrigo, the rest of the examination is unremarkable, all evolving in a context of febrile sensations and preservation of general condition. On the biological level the patient benefited from a blood count which showed hyperleukocytosis at PNN GB: 17360, PNN: 12378, CRP: elevated to 266, renal function: normal, ionogram; normal, a vaginal sample came back negative, the patient was placed on strict rest, compresses soaked in saline and dual antibiotic therapy by vein for 10 days then relay by oral route, entry point treatment with anti-mycotic with good clinical evolution and biological. Then she was put on preventive penitard and compression stockings, the patient has not had a recurrence since.

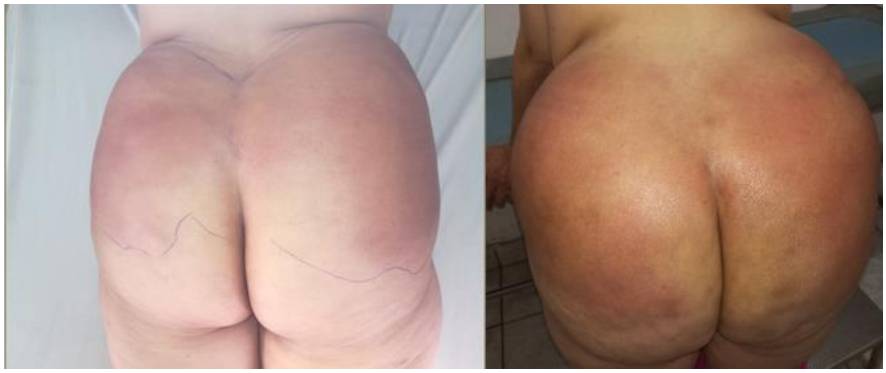

Figure 1: Clinical photo showing erythematous placard covering the 2 buttocks

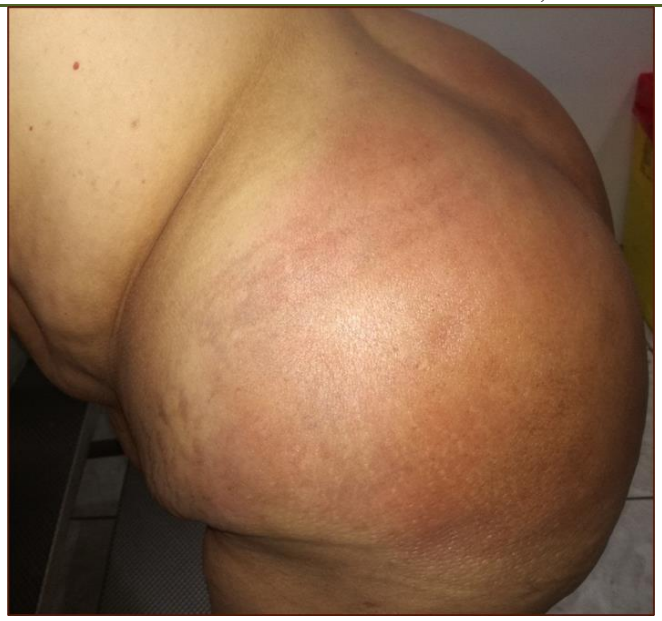

Figure 2: Profile view showing the limits of the erythematous placard

DISCUSSION

Erysipelas is an acute, superficial, dermo-hypodermal infection that generally affects the legs. It is commonly caused by streptococci [2], mainly group A, but sometimes groups C or G. The reservoir of an involved pathogen is often uncertain; the rectum and the spaces between the toes have been identified as possible reservoirs of streptococci [3]. The disease has been known since the time of Hippocrates, whose precise description is still valid. Erysipelas is a bright red, flame-like, spreading superficial edematous lesion with sharply defined margins. These signs, along with fever and general symptoms, confirm the diagnosis [4]. Extracutaneous symptoms are common and include regional lymphadenopathy, malaise, fever and chills. The diagnosis is mainly based on the clinical picture and supported by elevated C-reactive protein and leukocytosis [5]. Direct detection of the etiological agent and serology are not useful in clinical routine [6]. The development and progression of erysipelas are associated with systemic and/or local risk factors. Systemic risk factors may be liver and kidney diseases, heart failure, neoplasms, immunosuppression, diabetes, hyperuricemia, hyperlipidemia, hypertension, obesity, sitting, use of anti- non-steroidal inflammatory drugs, smoking and alcohol abuse [7] for gluteal location, the risk factors reported in the literature are: hip surgery or pelvic surgery and vaginal carriage of streptococcus [8, 9] in our patient she did not have vaginal carriage of streptococci or a history of pelvic surgery but she did have gluteal intertrigo. Erysipelas has a particular predilection for the lower limbs and the face. The process is usually unilateral, gluteal localization a Rare manifestations of erysipelas include atypical localization, unusual large spread of lesions and atypical morphology or course of the disease, as well as the absence of general symptoms [10]. The clinical features of erysipelas of the thigh and gluteal region have not been described in detail until now. The morphological differences between diaper erysipelas and lower leg erysipelas, as found in Glatz's study: are the female predominance, Diaper erysipelas often had clearly visible irregular edges and a purplish tint. Pain and Inguinal lymphadenopathy were observed significantly less often in erysipelas of the thigh and gluteal region.the majority of patients with diaper erysipelas did not have leukocytosis. These differences may result from distinct lymphatic pathways and less stasis compared to the lower leg [11]. The gluteal location poses a problem for differential diagnosis with Syndrome. of wells in its erysipeloid form, Panniculitis, Borrelliosis, Baboon syndrome. The treatment joins the management of erysipelas of the leg and is based on antibiotic therapy, treatment of the portal of entry, lymphatic drainage and restraint and antibiotic prophylaxis in order to alleviate the condition and prevent a relapse. In our patient who had another episode before, there was no recurrence upon initiation of antibiotic prophylaxis.

CONCLUSION

In conclusion, recognition of diseases with atypical and infrequent course and manifestations is crucial for early diagnosis and implementation of adequate treatment. Additionally, it helps to better understand the pathology behind the atypical manifestation. The diagnostic approach to rare clinical forms expands and enriches our understanding of the disease, helps prevent complications and is also a useful tool for testing our knowledge.

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Conflict of Interest: The authors declare that they have no conflicts of interest.

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