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CASE AND RESEARCH LETTERS

Non-Sexually Transmitted Acute Ulcer of the Vulva Associated With Influenza A Virus Infection

Úlcera vulvar aguda de transmisión no sexual asociada a infección por virus influenza A

To the Editor:

Nonsexually transmitted acute ulcer of the vulva (Lipschütz ulcer) is a rare condition characterized by the rapid onset of 1 or more large, deep ulcers in patients with no relevant past medical history. The etiology is unknown, though some studies in the literature have reported cases related to primary infection by pathogens such as Epstein-Barr virus (EBV), cytomegalovirus, influenza, *Toxoplasma*, and *Salmonella*. In the series of Farhi et al,[1] 33% of patients showed positive IgM serology for EBV and polymerase chain reaction analysis revealed the presence of the virus in biopsies of the lesions. We report a case of acute ulcer of the vulva associated with influenza A virus infection.

A 14-year-old patient with no relevant past history presented to the emergency department because of painful genital ulcers that had started 36 hours earlier and had been treated as a primary herpes infection (Figure 1). The patient stated that she had never had sexual relations and examination revealed an intact hymen. She also reported a 7-day history of sore throat, high fever, and malaise with asthenia and generalized myalgia that had been treated with antipyretics. On examination, the patient was afebrile and had bilateral, symmetrical (kissing) vulvar ulcers on the labia minora. The ulcers were 2 cm in diameter, had a necrotic appearance and a fibrinous base, were suppurating, very painful, and foul-smelling, and there was a bilateral reactive inguinal lymphadenopathy. Treatment with antibiotics (amoxicillin-clavulanic acid 500 mg/125 mg every 8 hours for 7 days), oral anti-inflammatory drugs, and absorbant topical dressings was prescribed. Complete blood count and biochemistry were normal. Serology was negative for human immunodeficiency virus types 1 and 2, hepatitis B and C virus, herpes simplex virus types 1 and 2, parvovirus, and syphilis. It also revealed positive immunoglobulin (Ig) G but negative IgM for *Toxoplasma gondii*, cytomegalovirus, Epstein-Barr virus, parainfluenza virus types 1, 2, and 3, adenovirus, and influenza B virus,

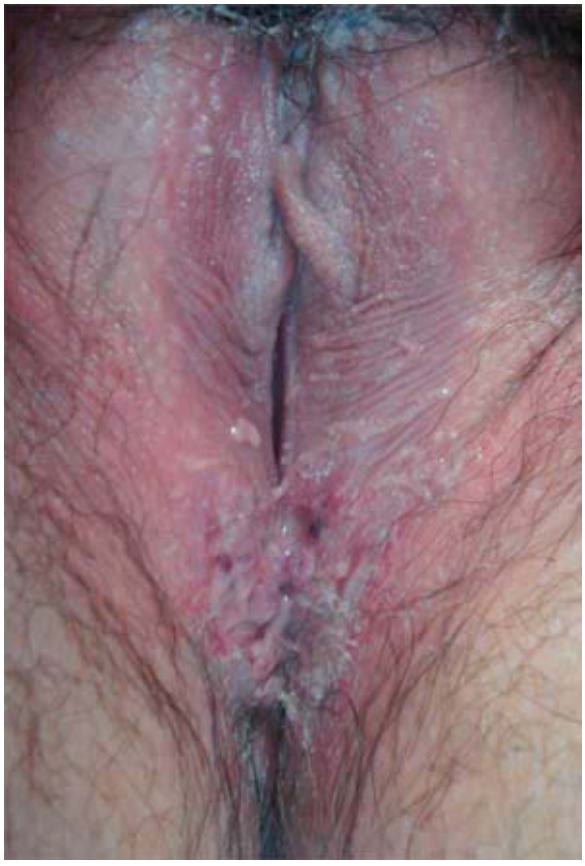

Figure 1 Bilateral, symmetrical, acute necrotizing ulcers of the vulva.

but positive IgG and IgM for influenza A virus. Cultures of the vulvar discharge and ulcers were negative. Follow-up evaluation of the patient showed complete healing of the lesions without scarring or recurrence.

Nonsexually transmitted acute ulcer of the vulva occurs in immunocompetent female children and adolescents who are not sexually active. Its clinical presentation is striking, with very painful crusted genital ulcers of rapid onset accompanied by fever and malaise. Differential diagnosis should include other causes of acute ulcers of the vulva, including sexually transmitted infections, trauma, genital aphthosis, and ulcerated lesions associated with

autoimmune diseases.[2] The course of this disease is self-limiting. The lesions resolve within 2 to 4 weeks without residual scarring or recurrence.[1]

Although its etiology is unknown, the development of this disease is associated with various viral infections, the most common of which is Epstein-Barr virus.[1,3-9] The case reported here involved acute ulceration of the vulva (Lipschütz ulcers), associated with primary influenza A virus infection. Because of the high incidence of infection by this virus and the great public alarm regarding the H1N1 serotype, we believe that it is important to study acute ulceration of the vulva and its relationship with influenza A virus infection.[10]

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Patch Testing Increases the Likelihood of Recognizing Lamotrigine as a Cause of Drug-Induced Rash

La imputabilidad de la lamotrigina en el exantema medicamentoso aumenta con las pruebas epicutáneas

To the Editor:

Lamotrigine, an aromatic antiepileptic drug, is mainly used to manage epilepsy and bipolar disorder and to stabilize mood. The most common adverse reaction to this drug is a skin rash that typically develops in the first 8 weeks of treatment.

The patient was a 64-year-old woman with a history of depression. She had been on treatment with ranitidine and venlafaxine for more than 2 years, and was also receiving lamotrigine. She attended the emergency department with a 4-day history of pruritic, erythematous macules and papules that showed cephalocaudal progression (Figures 1 and 2), discomfort in the mouth, and fever of 38ºC. She had been prescribed lamotrigine 12 days before the symptoms commenced.

A lamotrigine-induced drug rash was suspected. Treatment was therefore withdrawn and the patient was prescribed

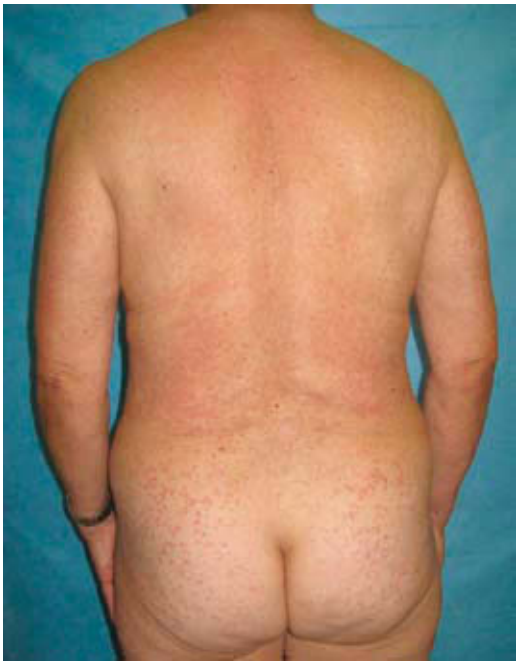

Figure 1 Skin symptoms.