

and post-natal period due to locally prevalent social taboos. She would eat only (overcooked) meat or chicken soup (initial broth being discarded) with polished rice which was prepared by the 'boil and drain' method. The duo had not received any nutritional supplements. At presentation to the emergency department, the infant was noted to have tachypnea (with grunting), encephalopathy and tonic posturing of her body. Investigations [reference range] showed severe metabolic acidosis (pH: 6.96 [7.35–7.45], pCO₂: 23 mmHg [35–45], bicarbonate: 5.7 mmol/L [22–26]) and elevated lactate levels (>15.0 mmol/L [0–2]). Magnetic resonance imaging (MRI) of the brain (done after clinical stabilisation) showed bilateral symmetrical T2-weighted hyperintensities in basal ganglia and frontoparietal cortex with diffusion restriction (Fig. 1). Other workup (including complete blood counts, serum biochemistry, cerebrospinal fluid analysis, body fluid bacterial cultures and chest imaging) was largely non-contributory. Treatment with a single

dose of intravenous vitamin B_x (and supportive care) resulted in a brisk improvement in clinical features and metabolic abnormalities (pH: 7.25, 7.44, pCO₂: 36, 28 mmHg, bicarbonate: 15.8, 19.0 mmol/L and lactate: 3.3, 0.7 mmol/L at 3 and 10 h of hospitalisation, respectively). Currently, she is doing well at 1 year of age with normal development (no further symptoms or episodes of acidosis). What is the likely diagnosis? (Answer on page 468)

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A non-healing perianal ulceration

Answer

This patient has a variation of haemangioma known as infantile haemangioma with minimal or arrested growth presenting as a non-healing perianal ulceration. The diagnosis was confirmed by skin biopsy demonstrating strong diffuse positive GLUT1 immunostaining at the endothelial lining of the dermal vessels.^{1,2} The arrested growth pattern explains the atypical appearance and the ulceration in the perianal area can possibly be explained by the fact that the early developing lesion is irritated by urine and faeces and traumatised by the necessary cleaning of the area.^{3–5} The perianal ulceration showed a rapid response with complete healing within 4 months of propranolol initiation (Fig. 1b). The morphology and location posed a diagnostic dilemma and required multidisciplinary evaluation to exclude alternate pathologies, including infantile inflammatory bowel disease, immunodeficiency disorders, a large segmental haemangioma and LUMBAR syndrome. This case highlights the importance of including infantile haemangioma among the differential diagnoses in neonates presenting with rapid onset perianal ulceration.

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