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CASE REPORT

Cutis marmorata telangiectatica congenita in a female newborn

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Abstract

This case report relates to cutis marmorata telangiectatica congenita diagnostic in a female newborn, performed shortly after her birth, through findings of violaceous cutaneous lesions in the lower limbs, lower quadrant of abdomen and left hand, which worsened after cold exposure. Complementary examinations were performed to verify presence of associated abnormalities, presenting alterations in the transfontanela ultrasound, eye fund examination and echocardiogram. The evolution of cutaneous lesions has been evaluated, as well as neurological, ophthalmologic and cardiological evolution to minimize impacts of these alterations, which are still unclear.

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INTRODUCTION

Cutis marmorata congenita telangiectatica (CMTC) is a rare cutaneous vascular condition that is characterized by the presence of an often asymmetric local or generalized pattern of erythematous or violaceous reticular macules, present from birth or shortly after birth, which resemble cutis Marmorata and may be benign and more common. First described in 1922 by the Dutch pediatrician Cato von Lohuizen, to date, more than 300 cases have been published worldwide, including four large series with more than 20 patients[1-4].

CMTC is commonly associated with other anomalies (in 20% to 80% of cases), revealing the importance of an accurate diagnosis. Usually the prognosis is good, and in the majority of cases, the skin lesions tend to improve or disappear in the first years of life[1-4]. The gender prevalence is controversial. Although it is said that females are most affected, the published reports do not shown any statistically significant differences[5].

The diagnosis is mainly clinical and the broad spectrum of cutaneous and extracutaneous manifestations of this anomaly is a frequent source of confusion, making differential diagnosis necessary[1-4].

We report here the case of an infant diagnosed with CMTC without associated anomalies.

CASE DESCRIPTION

A.P.F.R. newborn, 1st post-natal day, full term (GI: 37 weeks and 2 days), born by cesarean section due to maternal indication (specific gestational hypertensive disease), regular prenatal with negative serologies. RNT, weight 2720g, Apgar 9/9, without complications. Presence of violaceous macules in the lower third of the left lower limb, lower left quadrant of the abdomen and left hand, at birth. Lesions worsened after exposure to cold.

In the first hours of life the newborn evolved with sucking difficulty, and vomiting, requiring insertion of an orogastric tube, zero diet and clinical observation.

Favorable evolution, with discharge on the 10th post-natal day. Table 1 below shows the results of the complementary tests performed at the time of CMTC diagnosis in the newborn. Figure 1 A - F. show the violaceous and reticular macules in the patient in question.

Table 1. Complementary tests performed in the newborn during hospitalization.

Test	Results
Echocardiogram	Pervious oval foramen and mild pulmonary reflux.
Abdominal ultrasound	Without abnormalities.
Transfontanelle ultrasound	With previous grade II hemorrhage in reabsorption.
Fundoscopy	Optic nerve pallor and reduction of foveal brightness.

Source: Authors, 2016.



Figure 1. A - F. A.P.F.R. newborn images showing violaceous reticular macules corresponding to the diagnosis of CMTC.

DISCUSSION

Skin changes in CMTC usually become evident shortly after birth. In this instance, the clinical diagnosis was made in the delivery room, based on the appearance of the lesion.

This management of this disease focuses on monitoring any changes in the lesions, which tend to improve over time, and investigating any extracutaneous findings. This investigation is extremely important, because although the skin lesions are benign, approximately 50% of patients diagnosed with CMTC have associated abnormalities: asymmetry (mainly in the limbs), cleft palate, congenital cutaneous aplasia, glaucoma, mental or psychomotor deficit, cutaneous atrophy and ulcerations[6].

The patient in question presented changes in the transfontanelle ultrasound, eye fundus examination and echocardiogram (cited in Table 1). In addition to dermatology, the patient will also be seen by neurology, ophthalmology and cardiology, in order to minimize the impacts of these changes, which are still very subjective.

CONCLUSION

This work reports a case of Cutis Marmorata Telangiectatica congenita diagnosed shortly after birth. It is a rare case that usually manifests at birth or in the first hours of life. The patient should be monitored, because although the skin lesions are asymptomatic, other commonly-associated changes should be investigated.

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