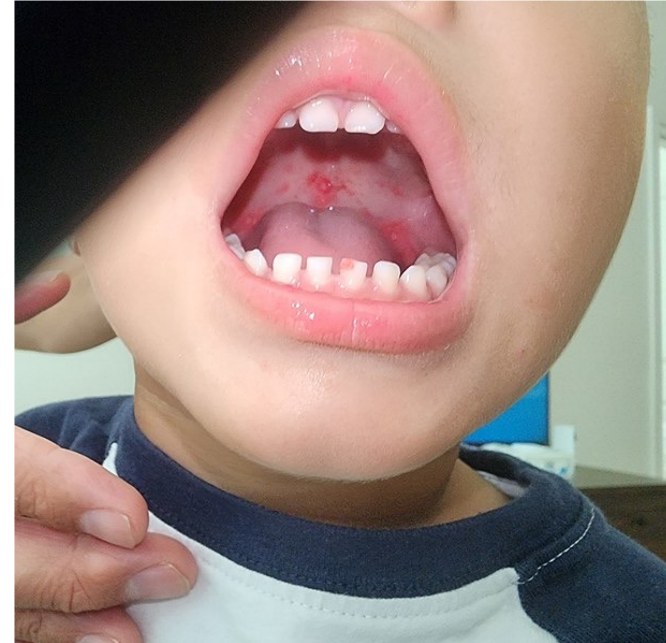
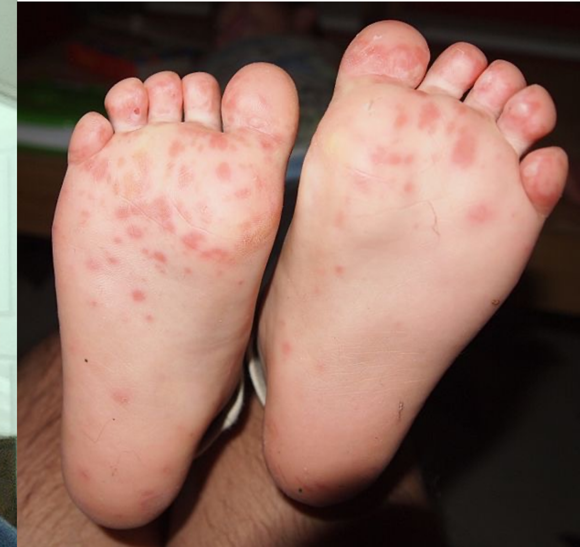
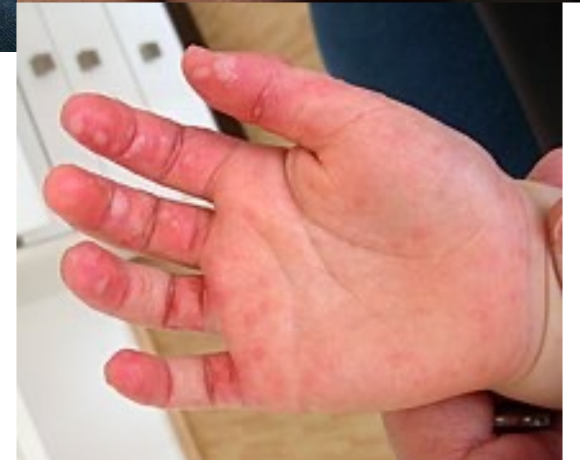
Hand-Foot-Mouth Disease

- Enteroviruses, esp Coxsackie A16 and Enterovirus A71
- Fecal-oral transmission, incubation period 2-7 days (avg 3-5), outbreaks esp summer & early Fall, most pts < 5-7yo
- Enanthem anterior to faucial pillars, tongue, buccal mucosa
  - Macules → vesicles w/red halo
- Exanthem palms & soles (can also → buttocks, knees, thighs, arms)
  - Maculopapular → vesicular
- Low-grade fever
- Clinical diagnosis

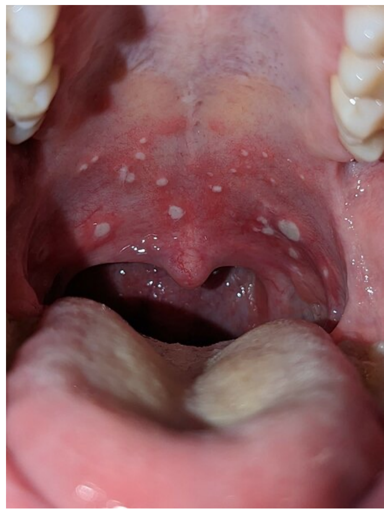






See slide 3 for treatment
See slide 4 for variant / complications

Photos from Wikimedia Commons



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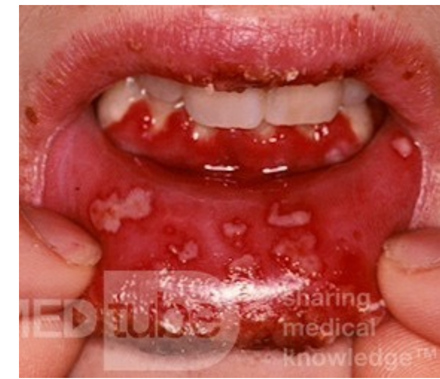


Viral Stomatitis

Herpangina

- Enteroviruses, primarily coxsackieviruses
- Fecal-oral transmission, incubation 1-10 days (avg 3-5), outbreaks esp summer & early Fall, most pts < 5-7yo
- High fever
- Papules → vesicles, anterior pillars, soft palate, tonsils, uvula
- No exanthem
- Clinical diagnosis

See slide 3 for treatment
See slide 5 for other HSV-1 variations

Herpes Gingivostomatitis

- HSV-1 (primary infection)
- Transmission direct contact with oral secretions, incubation 2 days – 2 weeks (avg 4 days), most pts 6mo-5yo
- Prodrome fever, anorexia, malaise
- Vesicles w/red halo on gingiva, buccal mucosa, tongue, hard palate
- Inflamed friable gingiva that bleeds easily
- Lips / perioral skin vesicles in 2/3
- Clinical diagnosis

HFM and HSV Stomatitis Management

Treatment

- Main concern: oral intake and dehydration
- Oral analgesics / antipyretics
- Encourage fluids (cold fluids, popsicles may be helpful)
- “Magic mouthwash” with viscous lidocaine +/- Maalox, diphenhydramine, sucralfate, used by some, not a lot of supporting evidence
- For HSV (but not HFM/herpangina) within 72-96 hrs of onset, *may* benefit from Acyclovir 15mg/kg (max 200mg) PO 5x/day x 5-7 days

Education

- No specific treatment for exanthem of HFM (not usually itchy)
- 1-2 weeks for complete resolution
- Fever may last several days
- Apply petroleum jelly to HSV lip lesions to prevent adhesions
- Return precautions for signs of dehydration
- Very transmissible, children infectious for average of 7 days
- Warn about potential complications of HFM (see next slide) – no need to return
- Herpes gingivostomatitis *not* generally sexually transmitted

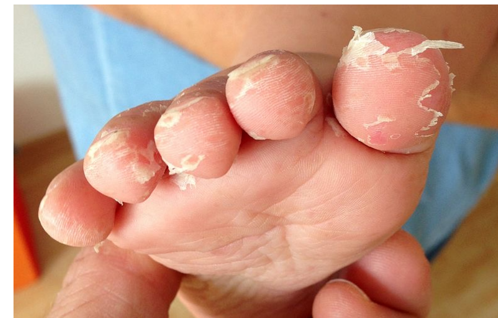
Coxsackie A6 HFM Variant

Clinical Features

- Higher fever than other HFM
- Wider distribution of exanthem, including face, perioral, groin, perineum, extremities
- Longer duration of symptoms
- Still a clinical diagnosis

Complications

- May have palmar and plantar desquamation 1-3 weeks later
- Onychomadesis (nails fall off – fingers and/or toes) may occur 3-8 weeks later
  - Nails grow back normally



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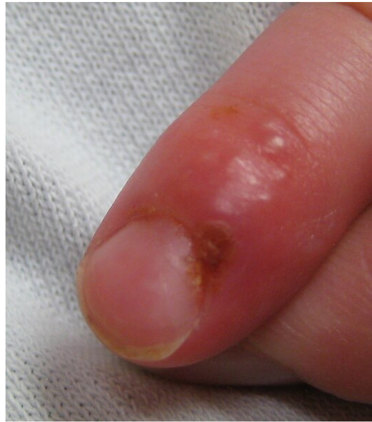
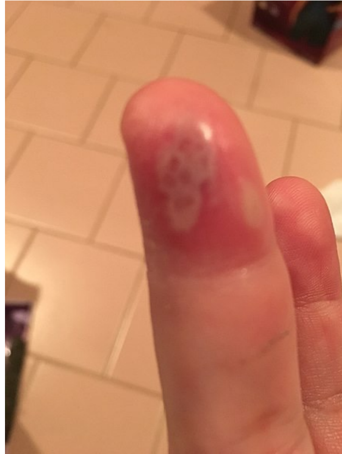
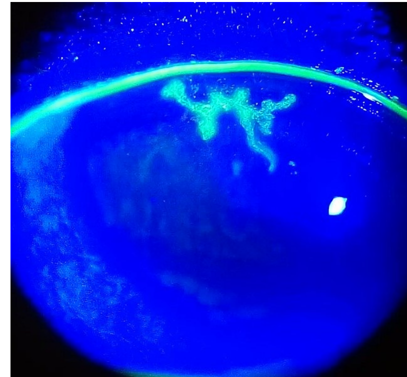
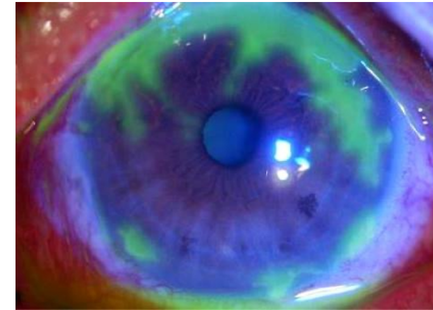
HSV-1 Variations

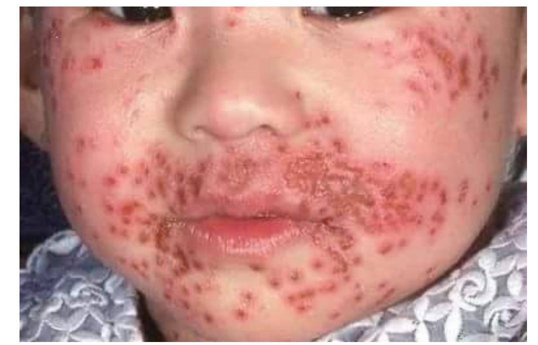
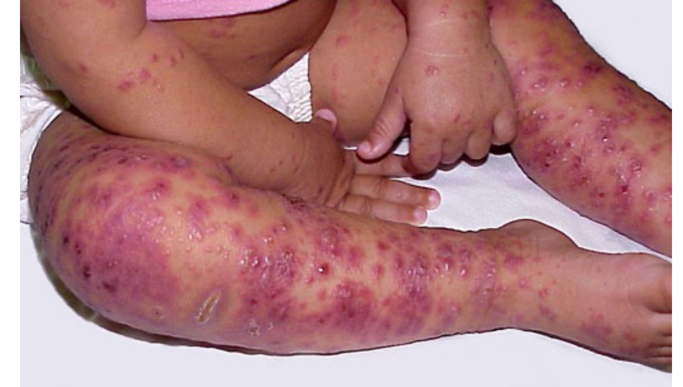
Herpetic Whitlow

- Single vesicle or cluster
- May transmit from sucking finger
- Occ associated flu-like symptoms or fever
- Clinical diagnosis
- Supportive treatment: rest, elevation, oral analgesics
- Lasts 1-2 weeks

Herpes Keratitis

- Suspect and test for if herpes lesions near eye
- Sx: pain, blurry vision, red eye, photophobia, watery discharge
- Fluorescein test shows corneal dendritic or geographic ulcer
- Urgent ophthalmology consult
- Oral acyclovir / valacyclovir and ophthalmic acyclovir

Eczema Herpeticum

- Rapidly spreading lesions in a patient with history of eczema
- Vesicles → crusts, punched-out erosions, hemorrhagic
- More common in young children
- Fever, malaise, may be ill-appearing
- Often admitted for IV acyclovir and IV fluids