

## A Perianal Ulcer in a Newborn: A Quiz

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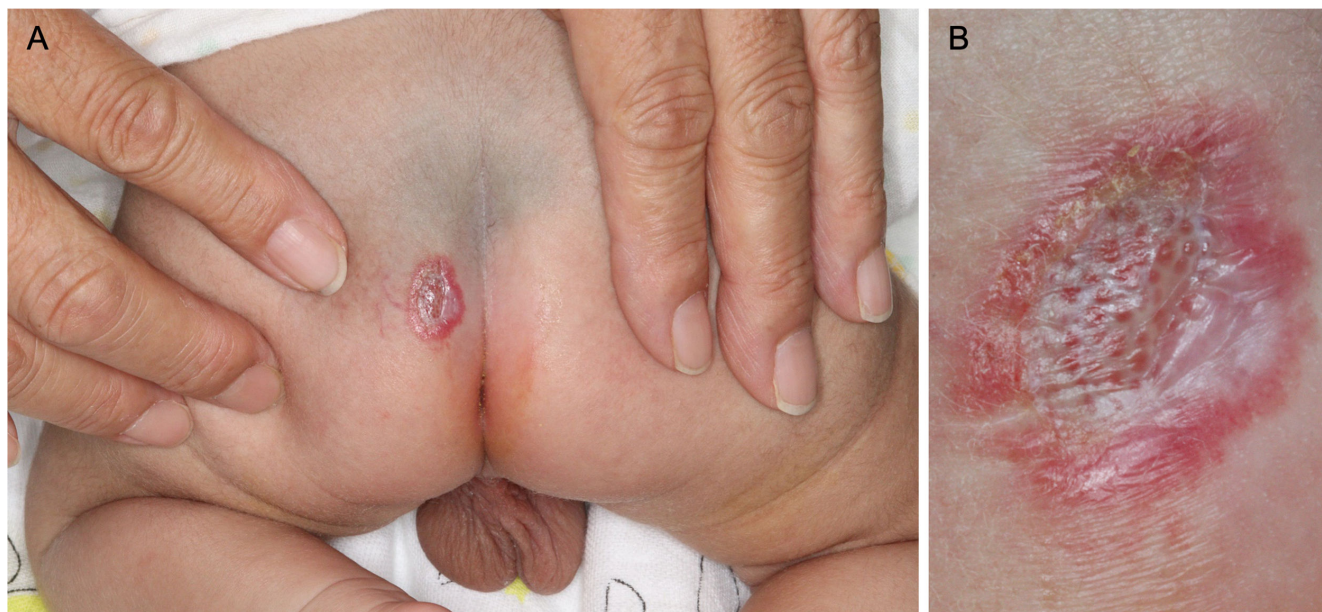
A 1-month-old newborn boy presented to our hospital with a skin ulcer on the left side of the gluteal cleft. His mother noticed the ulcer when he was 26 days old. He was referred to our paediatrician's office for a routine 1-month newborn check-up. The ulcer had increased in size, and he was subsequently referred to our department. On initial examination, a 10×5 mm ulcer within a 15×10 mm annular erythema was observed on the left buttock (Fig. 1). Topical application of zinc oxide ointment for 2 months to prevent diaper irritation resulted in epithelialization of the ulcer, but a slightly elevated erythematous macule 20 mm in diameter remained. He was born

spontaneously at 38 weeks and 4 days of gestation with Apgar scores of 8 at 1 min and 8 at 5 min, a birth weight of 3308 g, and a length of 49.5 cm, and demonstrated good growth at the 1-month check-up, with no other abnormal findings.

*What is your diagnosis?*

- 1: Pressure ulcer
- 2: Infantile haemangioma
- 3: Cutaneous nontuberculous mycobacterial infection
- 4: Kaposi's sarcoma

See next page for answer.



**Fig. 1.** Annular erythema, 15×10 mm in diameter, observed on the left side of the gluteal cleft (A). A shallow skin ulcer, 10 mm × 5 mm in diameter, present within the erythema (B).

## ANSWERS TO QUIZ

## A Perianal Ulcer in a Newborn: A Commentary

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**Diagnosis: Infantile haemangioma**

A skin biopsy specimen was obtained from the edge of the erythematous area (Fig. 2A). Histopathological examination revealed a dense proliferation of endothelial cells in the superficial and deep dermis. Dilation of capillary blood vessels was primarily observed in the superficial dermis (Fig. 2B). Based on these findings, the patient was diagnosed with an infantile haemangioma in the perianal region. Four sessions of 595 nm pulsed dye laser (Vbeam®) irradiation were performed (spot size 10 mm, pulse duration 20 ms, fluence 7 J/cm<sup>2</sup> for the first irradiation; spot size 7 mm, pulse duration 3 ms, fluence 10 J/cm<sup>2</sup> for the second to fourth sessions). The treatment was effective, and the erythema resolved with mild atrophic scar formation (Fig. 2C).

Secondary ulceration occurs in 16–23% of infantile haemangioma cases and is a common complication (1). However, to our knowledge, this is the first reported case of infantile haemangioma in which an ulcer in the perianal region was the initial symptom.

Infantile haemangiomas in the pubic and buttock areas are prone to secondary ulceration and require early treatment (2). Such lesions can ulcerate easily owing to abrasion, causing continuous pain during defecation, frequent bleeding and an increased risk of secondary bacterial infection. Diagnosis in this case was delayed because the ulcer was the initial symptom, which differs from the typical clinical features of infantile haemangioma. A skin biopsy was helpful in confirming the diagnosis, and treatment with a pulsed dye laser was effective in controlling the disease.

Some infantile haemangiomas enlarge rapidly, and depending on their location, may cause airway obstruction, visual field disturbance, feeding difficulties, hearing loss, urinary and defecation difficulties, hyperplastic heart failure and poor weight gain (1). Other cosmetic complications include atrophic plaques in markedly elevated lesions, residual fibrosis and subcutaneous

fatty degeneration. Glucose transporter-1 staining of the endothelium is sensitive for infantile haemangioma and is useful for differential diagnosis (1). Oral propranolol is widely used for cases requiring systemic treatment (2).

Decubitus ulcers may occur in areas where the skin experiences prolonged pressure in neonates and infants with low body weight or motor paralysis; however, none of these factors were present in this case.

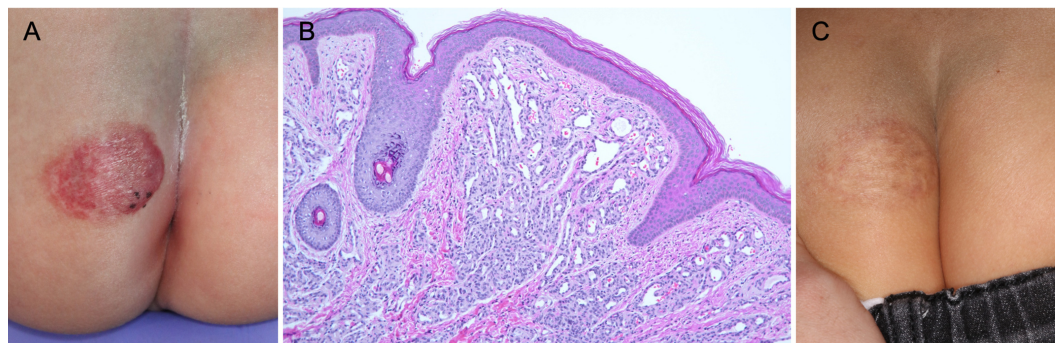
Cutaneous infections with nontuberculous mycobacteria or fungi may present as ulcers with minimal inflammatory signs, such as induration and local warmth. These infections are usually accompanied by necrotic tissues, and histological examination generally reveals the causative pathogens in association with granuloma formation.

Human immunodeficiency virus-associated Kaposi sarcoma has been reported in children (3), typically presenting as multiple red papules, nodules or erythema patches, although solitary lesions can occur (4). The clinical appearance of the present case differed from typical cases; however, histopathological evaluation was important to rule out malignant neoplasm.

In summary, postnatal ulceration of the buttocks in newborns can be associated with several conditions. In cases of infantile haemangioma, early diagnosis is important to ensure appropriate treatment and a good prognosis.

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**Fig. 2.** A skin biopsy specimen was obtained from the edge of the erythema where the ulcer had epithelialized (A). The specimen revealed dense proliferation of capillary vessels in all layers of the dermis, with dilation of blood vessels primarily in the superficial layers (B). Haematoxylin-eosin stain, original magnification  $\times 200$ . After four sessions of 595 nm pulsed dye laser (Vbeam®) irradiation (C).