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Early-onset Sulzberger-Garbe dermatosis: a rare pediatric case report

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Abstract: A 14-year-old patient with a long-standing history of seasonal, recurrent eczematous eruptions since infancy was referred to our dermatology clinic due to progression of skin lesions and intense pruritus. Physical examination revealed erythematous, infiltrated plaques with erosions and post-inflammatory dyspigmentation, predominantly on the extensor surfaces of the limbs. The trunk and face were unaffected.
Laboratory testing revealed mild relative eosinophilia (5.6%) in the complete blood count. Other routine tests were within normal limits. Histopathological examination of a biopsy specimen from the upper limb revealed features of acute eczema corresponding to Sulzberger-Garbe dermatosis.
This case highlights a rare pediatric manifestation of Sulzberger-Garbe dermatosis. Although classically described in adult males, the condition should also be considered in adolescents with chronic, pruritic dermatoses unresponsive to conventional treatment. Comprehensive differential diagnosis — including allergy screening and histopathologic evaluation — is essential to exclude other dermatoses that share similar clinical features.

Key words: Sulzberger-Garbe syndrome, eczema, pruritus.

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Introduction

Sulzberger-Garbe dermatosis is a rare dermatosis characterized by discoid, exudative, lichenoid skin lesions accompanied by severe pruritus [1]. It was first described in 1937 by dermatologists Marion Baldur Sulzberger and William Garbe [2].

Due to its clinical presentation overlapping with other dermatologic disorders and the absence of definitive diagnostic criteria based on objective biomarkers or histopathological features, establishing the diagnosis remains a significant challenge.

Recognition of this condition in the pediatric population is even more difficult, as certain features typically observed in adults may be absent, and literature data on pediatric cases are extremely limited.

The aim of this report is to present a case of early-onset dermatosis that was ultimately diagnosed as Sulzberger-Garbe dermatosis in a pediatric patient.

Case description

A 14-year-old boy with a long-standing history of seasonal, recurrent eczematous eruptions since infancy was referred to our dermatology clinic due to progression of skin lesions accompanied by intense pruritus. There was no personal or family history of atopy. Previous treatment with low- to medium-potency topical glucocorticosteroids (with or without topical antibiotics) had failed to provide adequate disease control.

Physical examination revealed erythematous, infiltrated plaques with erosions and post-inflammatory dyspigmentation, predominantly on the extensor surfaces of the limbs (Fig. 1A–C). The trunk and face were unaffected. Although not observed during examination, the patient reported intermittent lesions in the genital area.

Laboratory testing showed mild relative eosinophilia (5.6%) on complete blood count. Other routine laboratory parameters, including liver enzymes, creatinine, fasting glucose, and C-reactive protein, were within normal limits. Patch testing, prick testing, and both total and specific immunoglobulin E levels were negative.

Histopathological examination of a biopsy specimen obtained from the upper limb demonstrated features of acute eczema consistent with a diagnosis of Sulzberger-Garbe dermatosis.

Based on the chronic relapsing course, clinical morphology, poor response to standard treatment, negative allergy and autoimmune workup, and supportive histopathologic findings, the diagnosis of Sulzberger-Garbe dermatosis was established.

The patient was treated with potent topical corticosteroids (initially daily 0.05% betamethasone dipropionate, later switched to 0.05% clobetasol propionate as weekend therapy) and oral antihistamines (rupatadine 10 mg once daily). In addition, the patient received education on appropriate emollient use and was prescribed cholesterol-based ointment.

Only partial remission was achieved with topical therapy, and recurrent flares with crusted, exudative lesions continued to occur (Fig. 1D–F), particularly during the winter season. Due to this insufficient disease control, the patient was scheduled for phototherapy with excellent response.

Discussion

Originally, the Sulzberger-Garbe dermatosis was considered a disease affecting primarily middle-aged men of Jewish origin. However, subsequent reports demonstrated that it may occur regardless of age, sex, or ethnicity [3]. Most documented cases have come from North America. The rarity of reports may partially reflect underdiagnosis, as well as a tendency for cases to respond rapidly to systemic glucocorticosteroids, thereby limiting the need for proper diagnostic

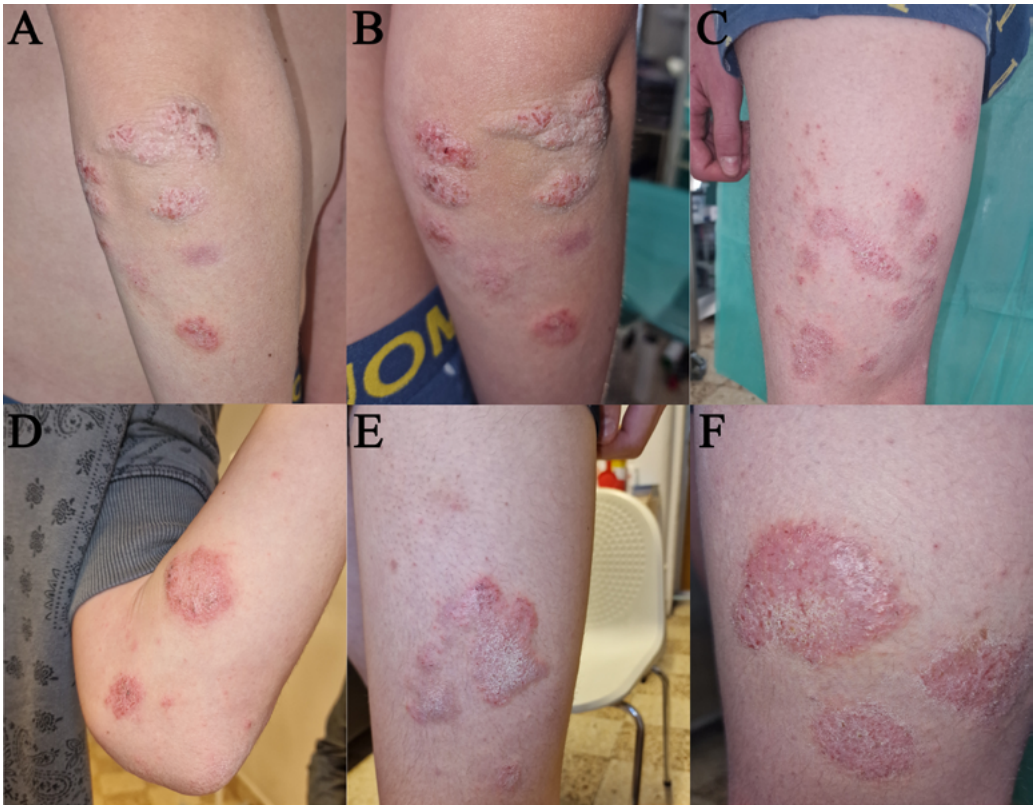

Fig. 1. A–C. Skin lesions observed at initial admission: erythematous, infiltrated plaques with lichenification, erosions, and post-inflammatory dyspigmentation, predominantly located on the extensor surfaces of the limbs. **D–F.** Disease exacerbation presenting as discoid erythematous lesions with exudative discharge and crust formation on the limbs.

evaluation [4]. Pediatric cases were previously reported in Poland [1] and Germany, where a 6-year-old boy and a 7-year-old girl were successfully treated with low-dose oral glucocorticosteroids [5].

To date, no studies have elucidated the pathophysiological mechanisms underlying the disease.

The classical evolution of lesions involves the emergence of discoid exudative plaques followed by lichenification; both forms may coexist and progress rapidly from one to the other [6]. The historical term "oid-oid" dermatitis referred to the suffixes of "discoid" and "lichenoid" [7]. During the healing phase, small urticarial lesions may appear. The most commonly affected areas include the trunk, extremities, and, in men, the genital region [8]. Pruritus is described as extremely intense — among the most severe in dermatology [1, 6].

The most typical laboratory finding is peripheral eosinophilia, as observed in our patient. However, this is a highly nonspecific marker and may occur in a variety of other conditions.

Histopathological findings commonly include mild endothelial edema and perivascular infiltrates composed of lymphocytes, granulocytes, eosinophils, and plasma cells. Spongiosis and parakeratosis may also be observed [9].

Depending on clinical presentation, additional tests such as allergy panels or fungal cultures may be warranted.

The differential diagnosis includes atopic dermatitis, superficial fungal infections, allergic contact dermatitis, lichen planus, prurigo nodularis, dermatitis herpetiformis (Duhring's disease), and cutaneous lymphoma — particularly mycosis fungoides [6]. Some authors suggested the condition may represent a clinical variant of nummular eczema [10]. However, notable differences support its distinction as a separate entity, including the pattern of lesion evolution, greater pruritus severity, and poorer response to topical corticosteroids [4, 11].

Many reports emphasize the rapid and robust response to low doses of systemic glucocorticosteroids as a characteristic of this disease. Such treatment should be continued until the condition enters its self-limiting phase. A few steroid-resistant cases have responded well to immunosuppressive therapy with azathioprine [12]. Earlier reports suggested improvement following a change in living environment, but this observation was not supported by later studies.

Narrow-band UVB phototherapy has also shown promising results [1]. In our case, phototherapy was recommended as the initial modality due to parental concerns regarding systemic corticosteroids. The response to treatment was remarkable, opening another therapeutic option in this rare disease.

Conclusions

We presented the second description of pediatric case of Sulzberger-Garbe dermatosis in Polish literature. The case highlights the importance of considering Sulzberger-Garbe dermatosis in the differential diagnosis of chronic, pruritic dermatoses in pediatric patients. Although rare, this condition warrants attention due to its distinct clinical course, impact on patients quality of life, and good answers to the available treatment modalities. Increased awareness among clinicians may reduce misdiagnosis and allow for earlier and more effective management.

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Conflict of interest

None declared.

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