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Gingival telangiectasias as an underrecognized sign of juvenile dermatomyositis

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Image in medicine

A 6-year-old girl, born to non-consanguineous parents, was admitted for progressive bilateral calf hypertrophy evolving over 3 months. Her history was notable for recurrent pruritic skin eruptions since the age of 3 years, with spontaneous resolution. On admission, she was afebrile and in good general condition. Clinical examination revealed bilateral calf enlargement without local inflammatory signs. Mucocutaneous examination showed erosive perioral cheilitis, bilateral symmetrical brownish to violaceous maculopapular lesions over the lower limbs, and

prominent telangiectasias involving the upper and lower gingivae, with extension to the cheeks. Neurological examination was unremarkable, with preserved gait, normal tendon reflexes, and no objective muscle weakness. Laboratory investigations showed mild muscle enzyme elevation, with creatine phosphokinase of 316 IU/L and lactate dehydrogenase of 263 IU/L. Lower-limb MRI was normal. Antinuclear antibodies and anti-transglutaminase antibodies were negative. Myositis antibody testing revealed positive anti-Jo-1 antibodies, with weakly positive anti-NXP2 and anti-Ku antibodies. In view of the chronic cutaneous involvement, mucosal vasculopathic lesions, and immunological findings, juvenile dermatomyositis was considered the most likely diagnosis. Treatment was initiated with oral prednisone at a dose of 1 mg/kg/day, methotrexate at 15 mg/m^2/week, and oral folic acid at 10 mg/week, administered at least 48 hours after methotrexate. Prednisone was maintained for 6 weeks, then gradually tapered every 2 to 4 weeks according to the clinical course, with regular reassessment and a target dose of 0.5 mg/kg/day by 3 months. This image highlights gingival telangiectasias as an underrecognized mucocutaneous sign that may assist in the diagnosis of juvenile dermatomyositis, particularly in atypical presentations.

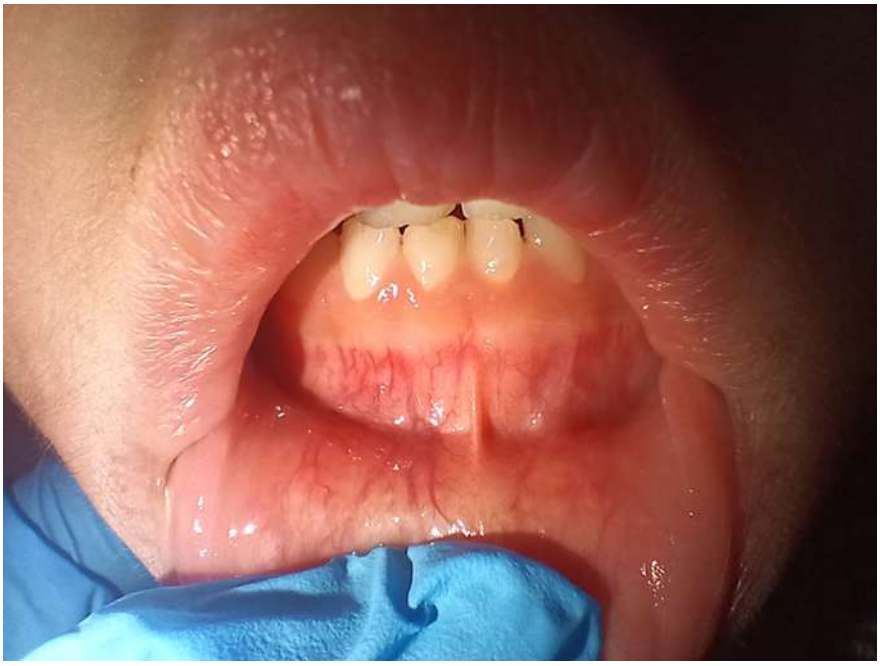

Figure 1: telangiectasias of the lower gingiva