



Bullous Impetigo

Büllöz İmpetigo

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A three-year-old girl was brought to the hospital with complaints of fever and rash. About two weeks prior, she had visited a health center with complaints of fever, fatigue, runny nose, and skin rash and was diagnosed with chickenpox. However, the skin rash developed into blisters, then spontaneously ruptured, sores, and spread throughout her body, forcing her to return to the emergency room. Physical examination revealed widespread, erythematous, crusty, circular skin lesions on the entire body. Laboratory tests revealed as WBC 7510/mm³, neutrophil count of 3710/mm³, lymphocyte count of 2980/mm³, and CRP of 1 mg/L. Clinically, the patient was suspected of having bullous impetigo, and intravenous ampicillin-sulbactam (150 mg/kg/day) was administered. A skin lesion swab culture positive for methicillin-sensitive *Staphylococcus aureus*. Blood and nasal cultures were negative. The patient received four days of intravenous ampicillin-sulbactam treatment. The lesions regressed, and the patient was switched to oral amoxicillin-clavulanate for a total of seven days. All skin lesions healed without sequelae during follow-up.

Bullous impetigo is a superficial skin infection seen primarily in infants and young children. Clear bullae most commonly appear on the face, trunk, buttocks, perineum, and extremities. The disease is caused by strains of *S. aureus* that produce exfoliative toxins. These toxins target desmoglein-1, leading to the formation of subcorneal vesicles. These vesicles then transform into flaccid bullae. When the bullae rupture, an erythematous base with a scaly border remains.



The lesions are highly contagious and spread easily. With early diagnosis and appropriate antibiotic treatment, they usually heal without scarring.

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