Full name: [redacted]

Sex: Female

Race: unspecified

Language: English

Religion: unspecified

Date of Birth & Age: [redacted], 30 months

Marital status: N/A

Date and time: 3/16/26, 10:30AM

Location: Queens Hospital Center

Source of history: Mother

Reliability: reliable

Referral source: self

Chief of complaint: Itchy rash since last night

History of Present Illness:

30-month-old female with no significant past medical history brought in by her mother to the ED for an itchy rash that began last night. The patient was previously evaluated on 3/8/26 and diagnosed with right otitis media with a positive rapid strep test, for which she was started on amoxicillin. She is currently on day 8 of a 10-day course. The mother reports that the patient's older sibling developed a similar rash x 3 weeks ago while on amoxicillin that resolved after discontinuation, prompting her to stop this patient's antibiotic as well. The last dose was given yesterday. No medications or topical treatments have been used for symptom relief. The mother denies fever, chills, decreased activity, ear tugging, runny nose, cough, vomiting, diarrhea, blood in stool or urine, wheezing or shortness of breath. No recent travel or new exposures to detergents, soaps, or lotions. Immunizations are up to date.

Past medical history:

- No reported past medical history

Allergies

- NKA

Vaccines: up to date

Past surgical history:

- No past surgical history

Medications:

- Amoxicillin 400mg/5ml suspension x 10-day course

Family history:

- No reported family history

Social history:

Housing situation: Patient lives with mother, father, and her elder sister. No exposure to tobacco smoke in home. No pets at home.

Daycare/school: N/A. Patient does not attend daycare or school.

Travel: No recent travels

Diet: Appropriate for age, consumes balanced diet including fruits, vegetables, protein. Drinks milk and apple juice. No known food allergies or feeding concerns reported. Appetite is good with no recent changes. 3 meals per day. 2-3 snacks per day.

Sleep: Average 10-12 hours. 1-2 daytime naps per mother. Had difficulty falling asleep last night; was reported crying intermittently for 1 hour.

Other: no recent changes to detergents, soaps, or lotions

Review of systems:

General: Denies fever, chills, decreased activity

Skin: Positive for pruritic rash bilateral upper & lower extremities, torso. Denies bruising, masses, other lesions

HEENT: Denies ear tugging, ear discharge, rhinorrhea, nasal discharge

Respiratory: Denies cough, shortness of breath, or wheezing

Cardiovascular: Denies murmurs, cyanosis

GI: Denies vomiting, diarrhea, melena, hematochezia

Genitourinary: Denies hematuria, changes in urine output

Musculoskeletal: Denies decreased activity, joint swelling

Neurological: Denies change of behavior, seizures

Physical:

- Vital signs
  - Temperature (F): 99 F oral
  - Heart rate: 95
  - Respiration rate: 26
  - Blood pressure: 93/55

- SpO2%: 99% RA

General: Patient appears active. She is not in apparent acute distress. Normal appearance, well kept, playful. She is not toxic appearing.

HENT: Atraumatic and normocephalic. No lice/nits noted on scalp. Tympanic membrane normal bilaterally. No nasal discharge noted. Nasal passage patent.

Eyes: pupils equal, round and reactive to light. No swelling, erythema, discharge noted.

Mouth: Mucous membranes moist. Small erythematous papules noted along the vermillion border. Inner oral mucosa not fully visualized due to patient being fussy and crying.

Neck/throat: negative lymphadenopathy

Cardiovascular: Regular rate/rhythm. No murmurs. S1/S2 normal

Pulmonary: Lung sounds clear to auscultation bilaterally. No wheezing, rhonchi, crackles noted. No respiratory distress. No accessory muscle use, nasal flaring, retractions.

Abdominal: Soft, non-distended. No tenderness, guarding, masses noted. Diffused mall pruritic erythematous papules noted.

Neurological: Patient is alert. No focal deficit noted.

Skin: Warm and flushed pink. Small pruritic erythematous papules noted bilaterally upper and lower extremities, palms, soles, interdigital space, and genital intertriginous areas. Skin turgor good. Cap refill < 2 secs

MSK: normal range of motion of upper and lower extremities

Assessment

30-month-old female with no significant PMHx presenting with an acute pruritic rash in the setting of recent amoxicillin use (day 8 of therapy). Rash is diffuse, involving bilateral upper and lower extremities, torso, palms, soles, finger webs, and genital intertriginous areas, with associated perioral erythematous papules. Patient is well-appearing, afebrile, hemodynamically stable, and non-toxic with no respiratory or systemic symptoms. Clinical presentation is consistent with hypersensitivity to amoxicillin. However, given the distribution of rash, hand foot mouth disease is a consideration.

Differential diagnoses

1. **Delayed hypersensitivity to amoxicillin –** Give the similar history with the patient's elder sister after amoxicillin use, a delayed amoxicillin rash is suspected. The rash is diffuse and pruritic without association with systemic symptoms. This suggests a possible benign reaction to the antibiotic. Additionally, the patient general appearance is well-appearing, playful, and non-toxic. Given the fact that it is day 8 of her 10-day course therapy, a delayed allergic reaction is suspected. Furthermore, no signs of immediate hypersensitivity are noted such as urticaria, angioedema or respiratory involvement.

2. **Hand-foot-mouth disease –** The distribution of the rash around the upper, lower extremities, palms, soles and perioral region is classic findings of this disease. Additionally, this disease is common in this age group, despite the absence of fever. Although the oral mucosa was not fully visualized and the fact that this disease is most common during the summer and fall, this exanthem cannot be ruled out yet.
3. **Scabies –** Due to nocturnal onset of rash and its distribution on the finger webs, extremities, and genital area, scabies is a possible differential, but less likely. It is less likely since there were no reported close contacts with similar symptoms
4. **Contact dermatitis –** Despite no reports of pets, change in detergent, soap, and lotion, contact dermatitis is still a concern. Rash is pruritic, which is hallmark feature. Nonetheless, pediatric patients are frequently exposed to potential irritants and allergen, sometimes without the parents noticing. Therefore, it is considered in the differential but less likely.

Plan

- Discontinue amoxicillin. Educated patient that this does not necessarily indicate true penicillin allergy.
- Follow up with PCP/pediatrician in 1-2 days or sooner if symptoms worsen for consideration of allergen testing.
- Dermatology referral
- Educate patient on possible viral exanthem and treatment mostly involves supportive care. Maintain hydration. Encourage adequate oral intake. Monitor for decrease intake. Use emollients if skin is dry.
- Return to ED if symptoms worsens or new symptoms arise such as difficulty breathing, wheezing, facial/lip swelling, persistent rash, fever, or decrease oral intake/signs of dehydration
- Discharge with Permethrin 5% topical cream and Calamine lotion