Sir,
Keratitis–ichthyosis–deafness (KID) syndrome is a genetically determined keratinization disorder characterized by ichthyosiform dermatosis with keratitis and deafness.[1] To date, just over 100 cases have been reported, most of which were sporadic in nature. KID syndrome is caused by mutations in the GJB2 gene, which encodes Connexin 26.[2]

We present a case of a 4-year-old male child with widespread alopecia of the scalp and torso, distinct hyperkeratotic hyperpigmented plaques over the body, and thickening over palms and soles with bilateral sensorineural deafness.

A 4-year-old male, preterm child born of non-consanguineous marriage with a history of diffuse transient erythema at birth presented to our center. Later, the skin over the face and extremities started to turn dry, dark, and rough which was progressive with recurrent episodes of pustular lesions on the scalp, eyelid, and trunk. History of photophobia and decreased hearing were present. There was no history of collodion membrane at birth, teeth abnormalities, or hyperhidrosis/hypohidrosis. Gait was normal. No other congenital abnormality or systemic disease was detected. There was no similar family history.

Examination revealed diffuse alopecia with sparse hair over the vertex of the scalp with multiple folliculitis lesions and follicular atrophy [Figure 1a and b]. Clinical and microscopic investigations revealed normal hair shaft. There was ciliary and supraciliary madarosis. There were multiple hyperpigmented hyperkeratotic plaques over the scalp, neck, trunk, and extensor aspects of the extremities. Both the dorsae of hands [Figure 2a and b], elbows, knees [Figure 2c], and feet showed the presence of diffuse hyperkeratosis with verrucose surface. There was bilateral palmoplantar keratoderma with a leather grain appearance [Figure 3]. Examination of the oral mucosa and nails was unremarkable. Vascularizing keratitis was discovered during the slit-lamp examination [Figure 4].

The patient was recommended for a cochlear implant after an otolaryngologic examination confirmed bilateral moderate to severe sensorineural hearing loss. Routine tests such as a full hemogram, a liver function test, and a renal function test were normal.

In 1981, Skinner stamped the abbreviation “KID” (keratitis–ichthyosis–deafness) syndrome.[3] The initial symptom is a frequently transitory erythroderma at birth or during infancy. Most people ultimately develop erythrodermatoderma. The plaques prefer the knees, elbows, and face, and they frequently have radial furrows around the mouth. Mostly a typical palmoplantar keratoderma with a grainy, reticulated, or stippled surface is present, as in this case. Dystrophy and leukonychia are possible nail changes.

Hair is usually normal, but some show lusterless hair or alopecia of the scalp, eyelashes, and eyebrows, as seen in this case. Sensorineural hearing loss is usually severe and bilateral as in this case, which may lead to developmental delay in speech.

Approximately 95% of individuals have ocular involvement, which generally manifests as photophobia and blepharitis after birth, during infancy, or early childhood. With increasing age, vascularizing keratitis and conjunctivitis develop and worsen.[4]

Ocular lesions arise later in KID syndrome than the other abnormalities, and symptoms...
may not present until adolescence.\textsuperscript{[5]} As in this case, intelligence is usually unaffected.

Early diagnosis is vital to prevent speech impairment. Overall prognosis is favorable except for the risk of development of SCC of the mucosa of the eye and oral cavity.

A multidisciplinary approach is necessary. Although less effective, topical retinoids and keratolytics are used to treat hyperkeratosis as used in this case. Systemic isotretinoin and acitretin can be tried in severe cases. Keratitis is treated with lubricating and anti-inflammatory drugs, which have varied degrees of success. In this case, artificial teardrops were used. Sensorineural deafness can be treated with cochlear implants, as planned in this case.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.
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Conflicts of interest

There are no conflicts of interest.

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