



Paediatric Dermatology

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Overview

- Basics for management of eczema
- Management of complications of eczema
- When to refer
- Other common dermatology presentations in paediatrics



Atopic Eczema

Infantile phase



invariably acute inflammatory changes affects the scalp, forehead, ear and neck in a 'balaclava-like' distribution also involves the upper trunk and extensor limb surfaces, typically sparing the napkin area

Childhood phase



pruritic, ill-defined, erythematous, scaly patches with exudate, crust and excoriations with the beginnings of lichenification
predilection for flexural sites: the antecubital and popliteal fossae are most commonly affected
also affects the neck, wrist and ankle flexures, buttock and thigh creases

Triggers

- Irritants
- Skin infections
- Contact allergens
- Food allergens
- Inhalational allergens

What else could it be?

Discoid (nummular) eczema

often present in older children and presents as coin-shaped lesions of eczema

most commonly misdiagnosed as psoriasis

more resistant to treatment

Seborrhoeic dermatitis

manifests in infants as cradle-cap crusting of the scalp or shiny salmon-coloured patches of dermatitis in the napkin area

Contact dermatitis

consider when distribution is atypical (eg periocular or hand dermatitis)

often suspicion raised in the history

Psoriasis

affects the napkin area in infancy

in older children it has a more typical distribution, affecting the scalp, trunk and joint extensors

often asymptomatic (where AE is intensely pruritic in contrast)

Scabies

extremely pruritic

burrows and hyperpigmented nodules; look for palmoplantar pustules and burrows in infants

ask regarding pruritus in other family members

Dermatophyte infections

varies in presentation, often pruritic and scaly, but can vesiculate, weep and crust when associated with acute inflammation

one should always have a low threshold to send skin scraping to mycology in a recalcitrant scaly eruption

This eczema plan belongs to: _____ Date of Birth: _____

Allergies: _____



IMPORTANT! If skin is crusty, weepy or blisters, speak to a healthcare professional at your surgery the same day



STEP

1

Moisturise all over EVERY DAY even when my skin is not red/itchy



My moisturiser:

Use all over and often (usually twice daily)



Avoid soap and bubble bath

My non-soap product for washing hands and body:

[Video Clip](#)

To see a video about how to apply your moisturiser go to www.bris.ac.uk/ewap/videos

Bath for a Max of 10mins

Red/itchy skin

Clear skin for 48 hours



STEP

2

If skin is red or itchy, continue to use your moisturiser **plus a flare control cream/ointment** applied to the affected areas only



Flare control cream/ointment for my face:

Once/twice daily for ___ days

Flare control cream/ointment for my body:

Once/twice daily for ___ days



One fingertip treats an area the size of 2 adult hands.

[Video Clip](#)

Apply at least 15 mins before or after moisturiser using the fingertip unit method: www.bris.ac.uk/ewap/videos

No improvement within 7-14 days



STEP

3

If skin is still not getting better speak to a healthcare professional at your surgery _____

Management basics

- Education, education, education
- Written eczema management plan (<http://www.bristol.ac.uk/primaryhealthcare/researchthemes/apache/ewap/>)
- Enough emollients for different settings
- Soap substitute
- Corticosteroids for flares
- Rule out infection if not responding

Prepared by: _____ Date: _____

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Emollients

- Large quantities – 250-500g per week
- Let families try different ones and see what works – ointments better for younger children
- Ideally use pumps and avoid hand contamination
- Apply in direction of hair growth
- No rule vs steroids – just have 20-30 mins in between





Bathing

- Daily
- Short time – before skin becomes wrinkly
- Pat dry
- **Bath and shower oils** – can be very slippery! E.g., Dermol 600, Oilatum
- **Soap substitutes** – Avoid bubble bath or cosmetic soaps and substitute. e.g., Dermol 500, Aquamax, Hydromol
- Use steroids and emollients

Steroids

- When prescribed in short courses or flares are not usually associated with side effects – use until skin is smooth
- Prescribe for **once or twice daily use**
- Use mild or moderate potency steroids for 7-14 days on the face and neck
- Use moderate or strong potency steroids for 7-14 days for areas below the neck
- **Use for 48hrs after flare** improves to prevent relapse
- Do not prescribe potent steroids without expertise or advice
- If not responding, consider infection and swab the area
- Consider 'weekend therapy' in frequent flares



Bacterial infection

- Parental education into signs and symptoms
- **Swab** areas – bacterial and viral
- **Flucloxacillin** first line or **macrolide** (nb palatability)
- If Group A beta-haemolytic strep – give 2 weeks course
- Consider antiseptic washes e.g., chlorhexidine or Octenisan if colonised
- Consider eczema herpeticum if not improving
- Withhold steroids from infected area until treated



Eczema herpeticum

- Start oral acyclovir if localised whilst waiting for swab result
- If widespread - treatment with **systemic acyclovir** should be started immediately and the child **should be referred for same-day specialist dermatological advice.**
- If involves the skin around the eyes, the child should be treated with **systemic acyclovir** and should be referred for same-day ophthalmological and dermatological advice
- Now recommendation is to continue steroids



Eczema Cocksackium

- Cocksackie virus A6, A16
- Child systemically well
- Blisters less tense 'bubble-wrap'
- Can involve palms and soles, mouth ulcers rare
- Preceding diarrheal illness
- Send swabs/stool
- Conservative management
- Refer if not sure same day



The background features a vibrant, abstract design. The top half is a warm gradient of yellow and orange, transitioning into a horizontal band of purple, pink, and red. Below this, the background is a mix of light green and teal. The design is composed of various overlapping geometric shapes, including triangles, squares, and circles, some with a textured, speckled appearance. A thin white horizontal line is positioned below the text.

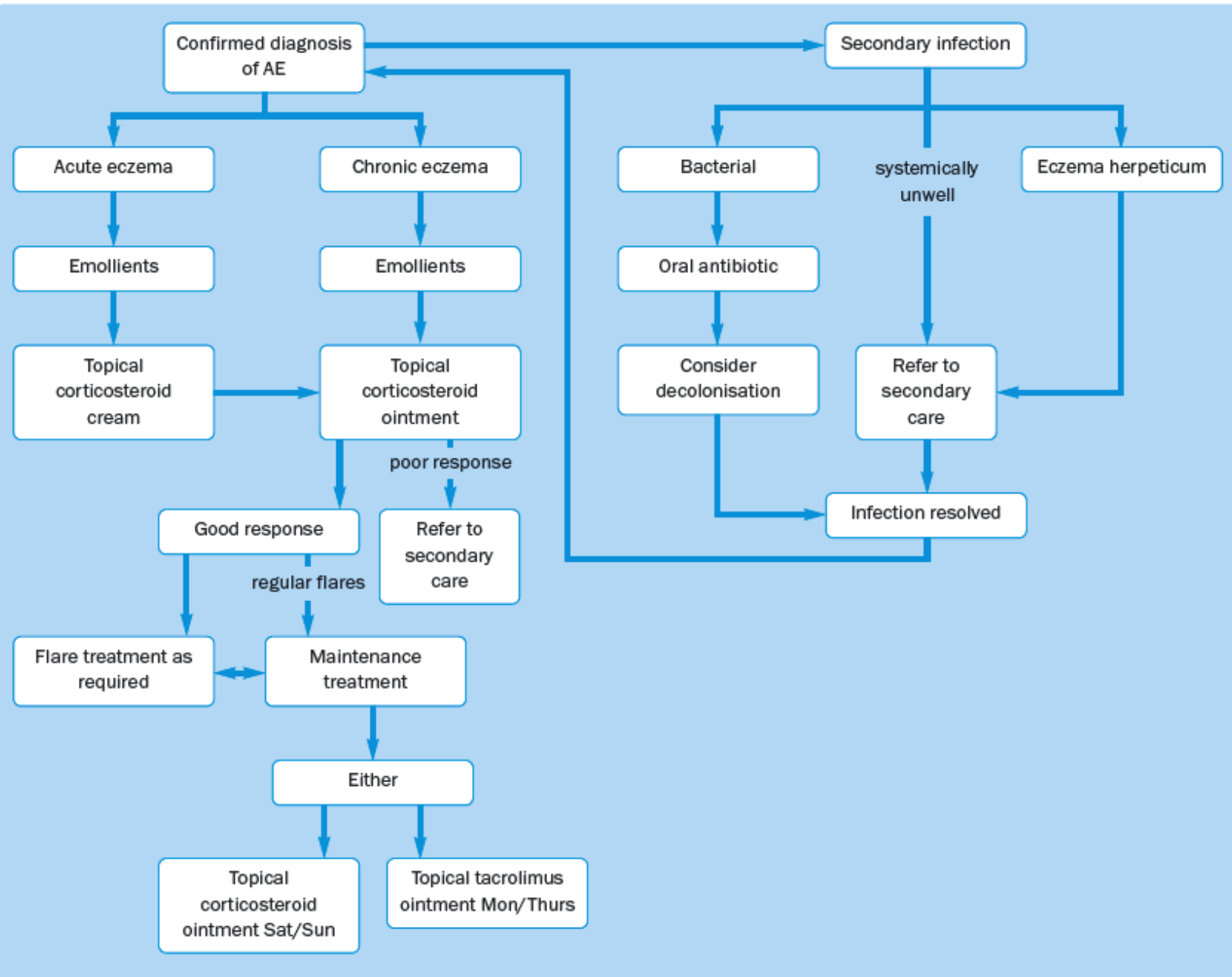
Other variants of eczema



Discoid Eczema



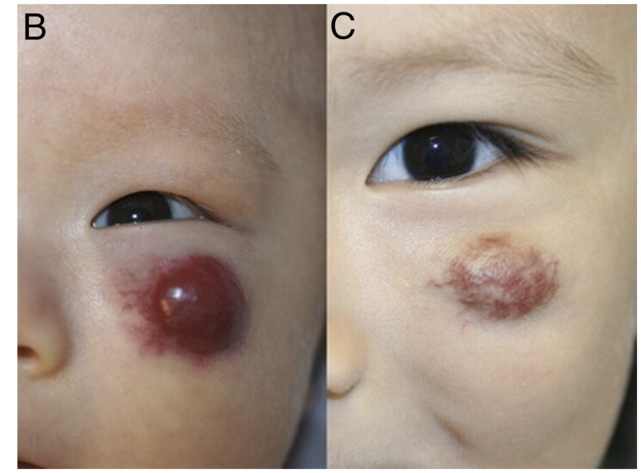
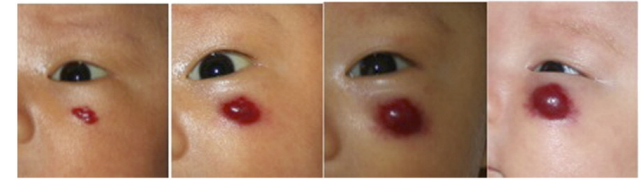
Pompholyx or Dyshidrotic eczema



Referral pathway

A close-up, top-down view of a woven basket filled with fresh, ripe strawberries. The strawberries are bright red with visible seeds and green leafy tops. The basket is lined with a light-colored, textured material, possibly straw or paper. The lighting is soft, highlighting the texture of the fruit and the basket.

Infantile haemangiomas



Infantile haemangiomas



When to refer

Management basics

- Active non-intervention – take a photo!
- Prevent drying and ulceration with an ointment e.g. diprobase
- Antimicrobial wash e.g. dermol 500
- Ulcerated haemangiomas
 - Pain relief
 - Antibiotic topically e.g. polyfax ointment (anti-pseudomonal), trimovate cream – not flucloxacillin
 - Seek specialist advice early



Figure 1: Pyogenic granuloma in the frontal area above the right eyebrow in a 9-year-old girl



These are not infantile hamangiomas!

Summary

- Skin conditions often cause a lot of anxiety
- Most can be managed easily and with reassurance and education
- If not sure, seek advice from dermatology team, usually very accessible and amenable to photo consultations
- Know your local stock

References

- British association of dermatology <https://www.bad.org.uk>
- British society of paediatric dermatology <http://bspd.org>
- Dermnetnz <https://dermnetnz.org>
- Eczema written action plan <http://www.bristol.ac.uk/primaryhealthcare/researchthemes/apache/ewap/>
- Great Ormond street hamangiomas <https://www.gosh.nhs.uk/conditions-and-treatments/conditions-we-treat/haemangiomas/>
- NICE guideline eczema <12yrs <https://www.nice.org.uk/guidance/cg57/resources/atopic-eczema-in-under-12s-diagnosis-and-management-pdf-975512529349#:~:text=Healthcare%20professionals%20should%20offer%20children,one%20product%20for%20all%20purposes.>



Other common rashes

Café au lait macules



Acne neonatorum





Neonatal
cephalic
pustulosis



Epstein's pearls/Bohn nodules



Seborrheic dermatitis

Mastocytoma





Subcutaneous fat necrosis



Galderma SA

021641H

Epidermal naevi



Congenital melanocytic naevi
