Paediatric Dermatology

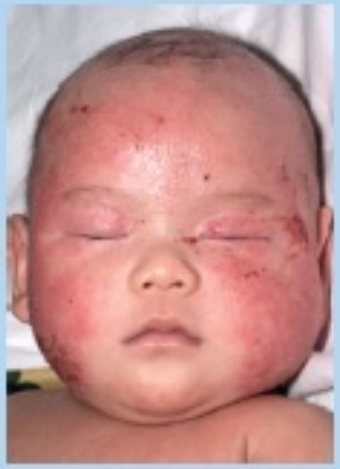
G ELEFTHERIOU

Overview

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

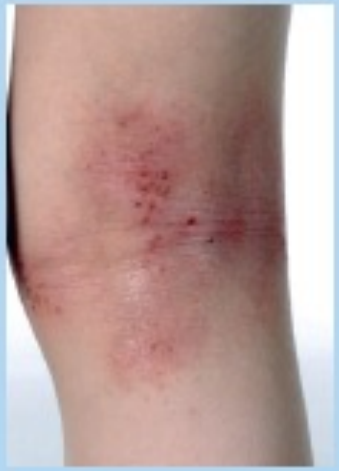
Atopic Eczema

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

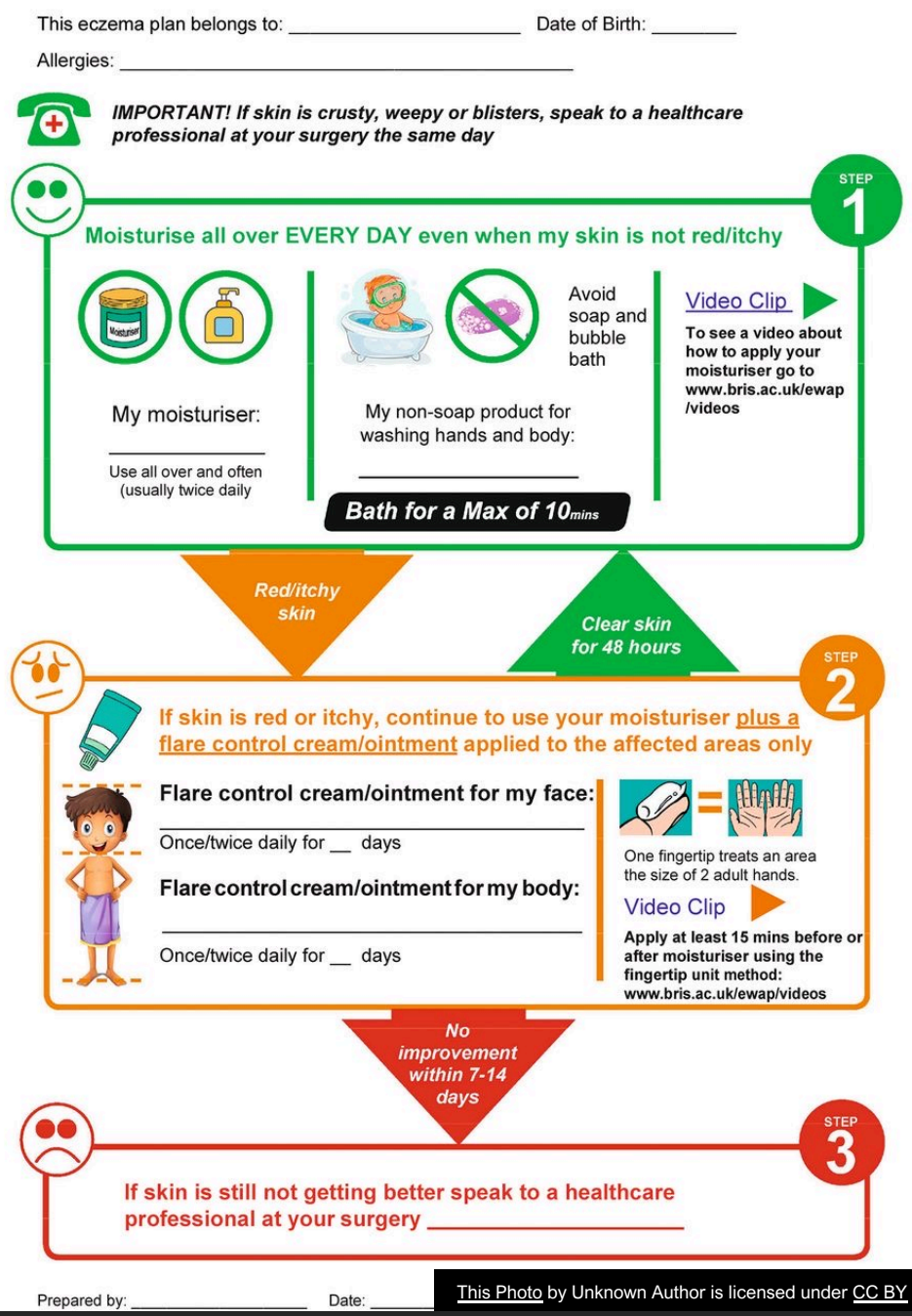
Seborrhoeic dermatitis
manifests in infants as cradle-cap crusting of the scalp or shiny salmon-coloured patches of dermatitis in the napkin area

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



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

Emollients

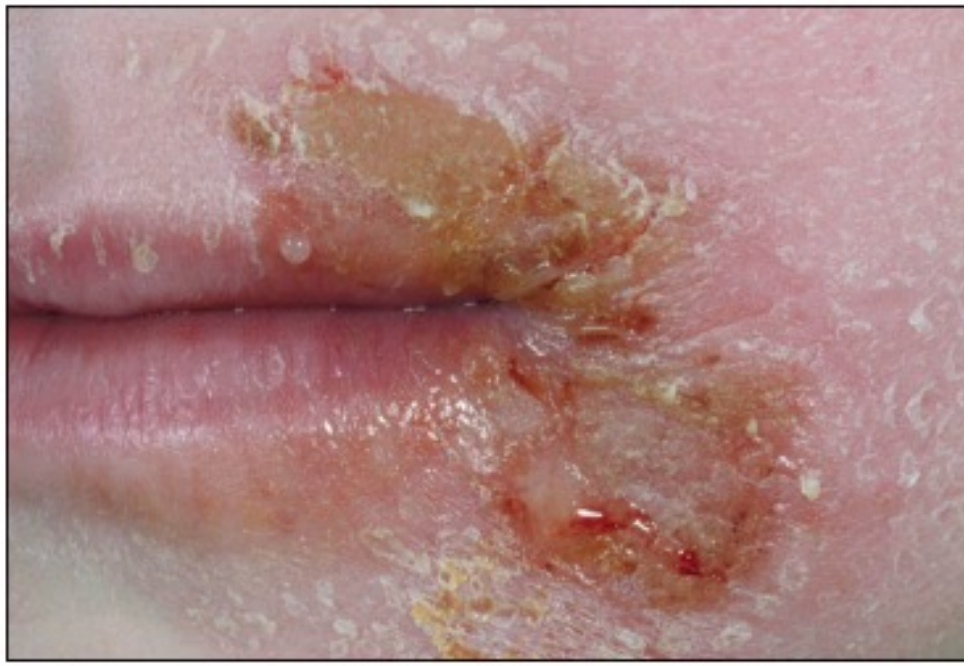
- Large quantities – 250-500g per week
- Let families try different ones and see what works – ointments better for younger children
- Ideally use pumps and avoid hand contamination
- Apply in direction of hair growth
- No rule vs steroids – just have 20-30 mins in between

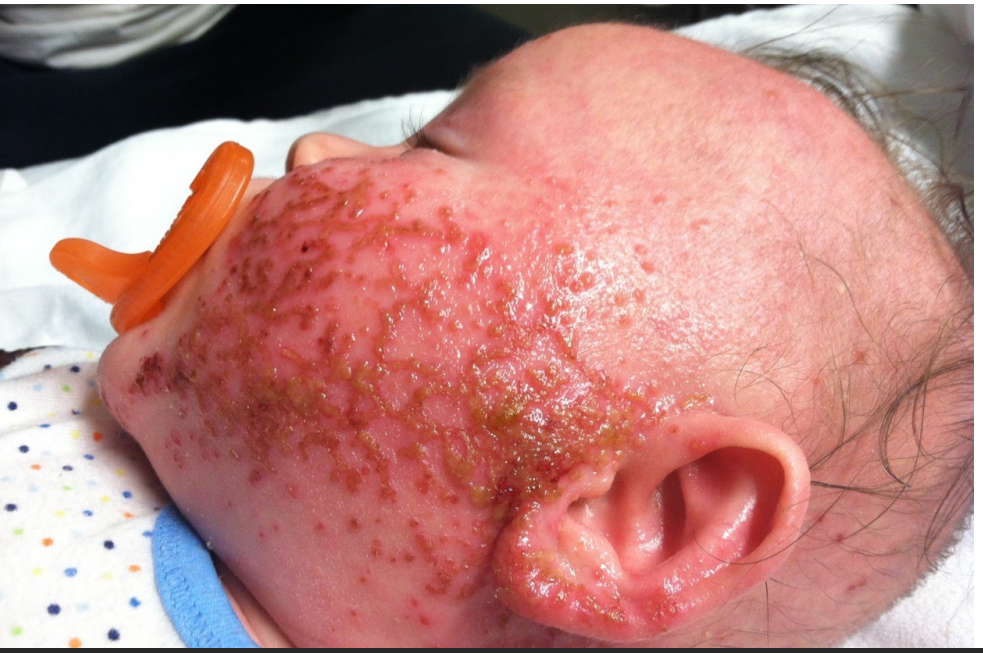
Bathing

- 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



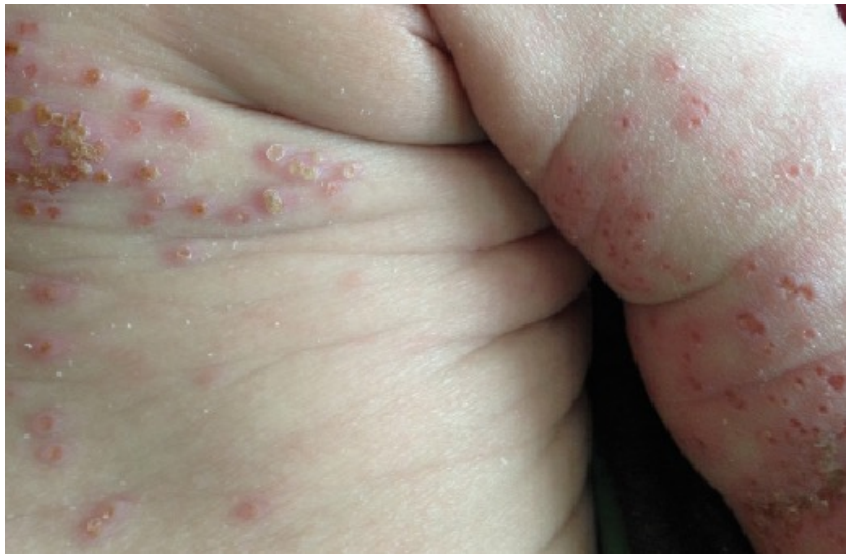


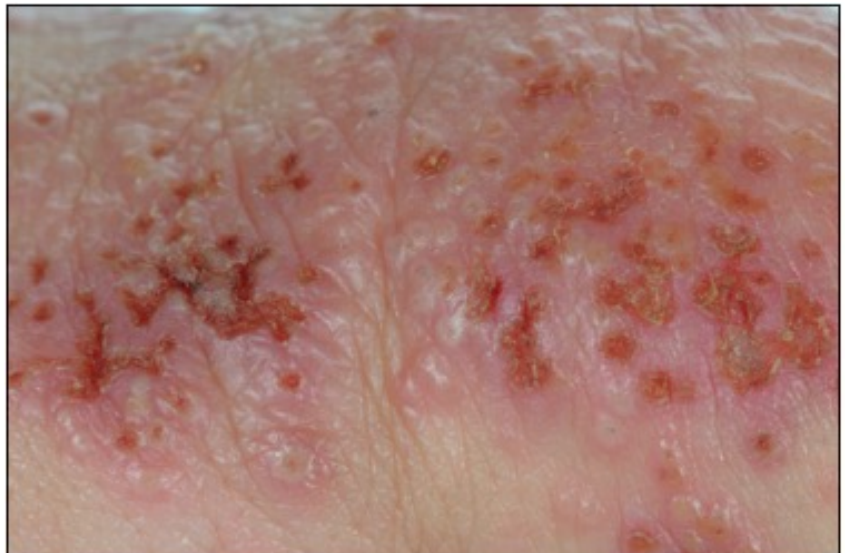
Bacterial infection

- 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

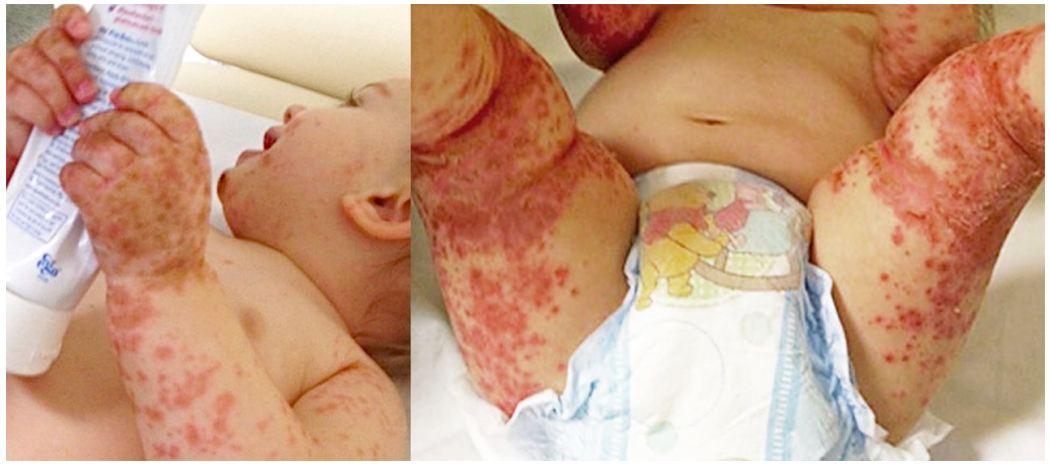
- Start oral acyclovir if localised whilst waiting for swab result
- If widespread - treatment with **systemic acyclovir** should be started immediately and the child **should be referred for same-day specialist dermatological advice.**
- If involves the skin around the eyes, the child should be treated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

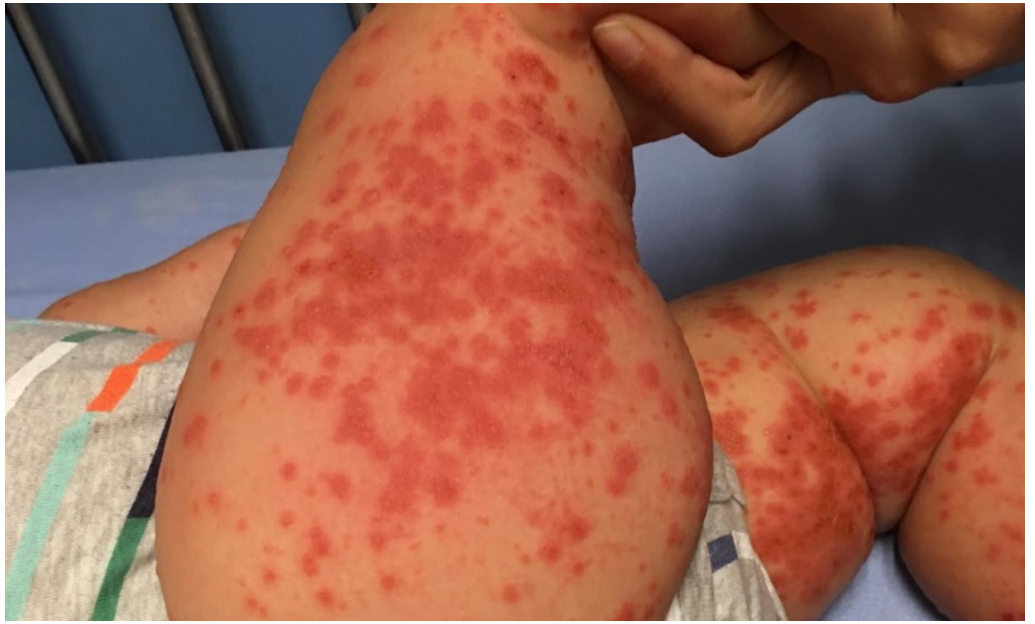




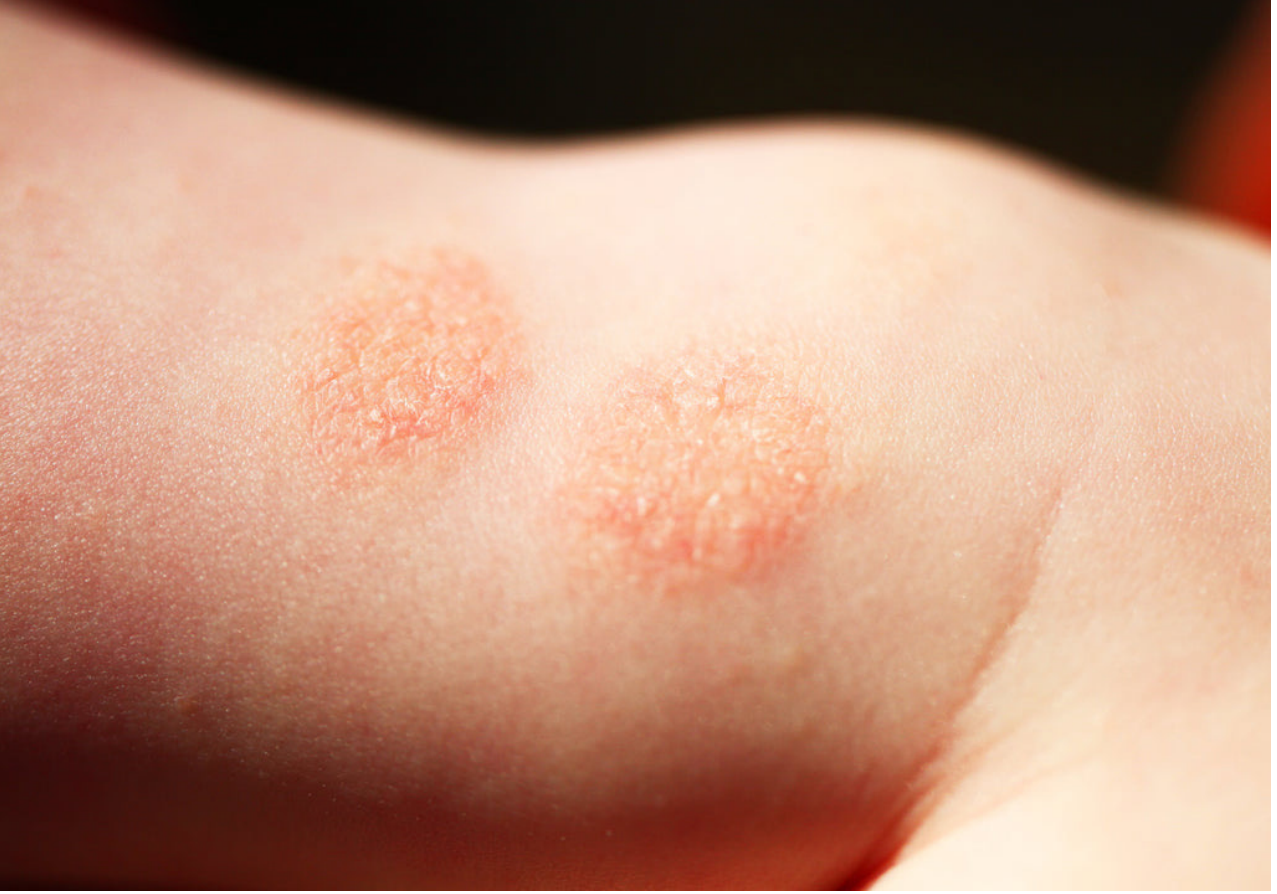
Eczema Coxsackium

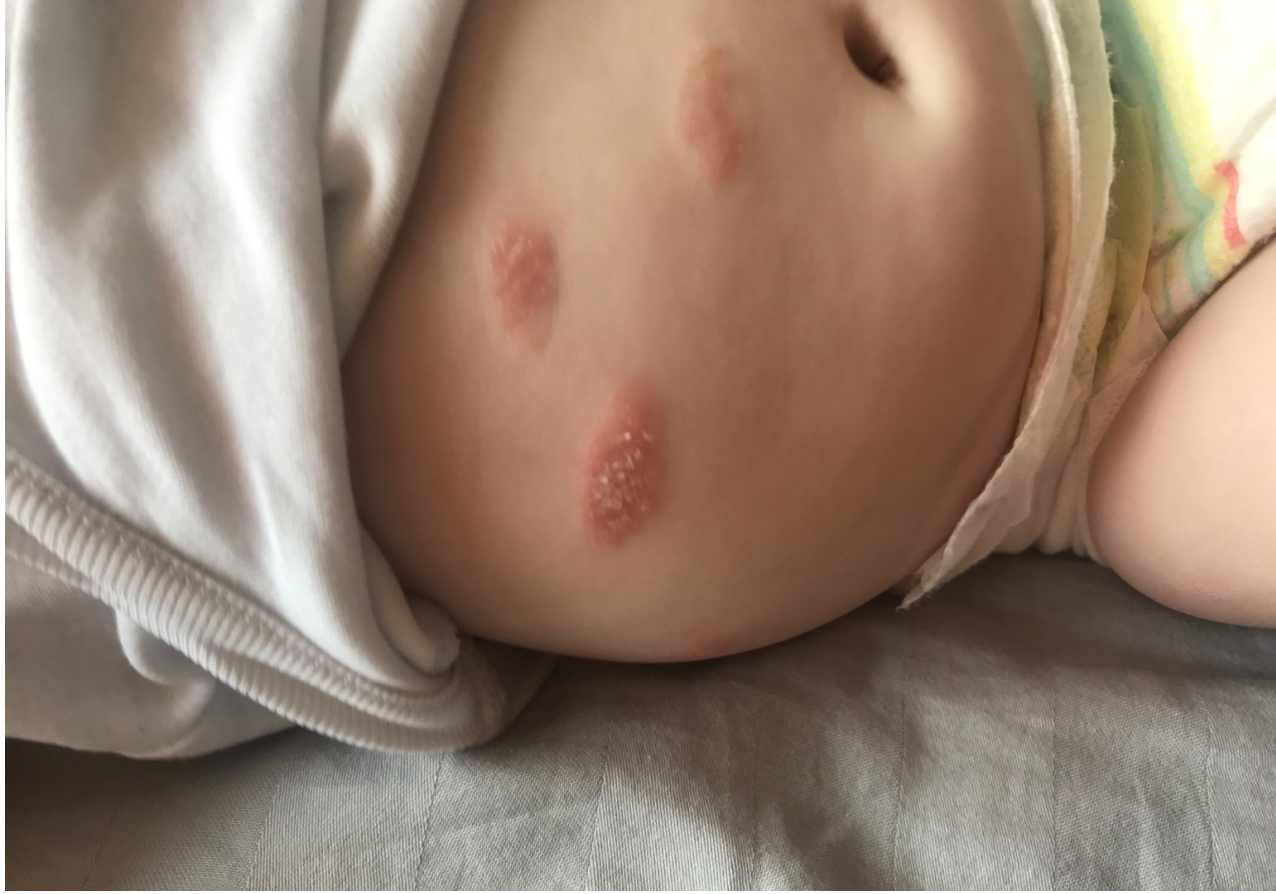
- Coxsackie virus A6, A16
- Child systemically well
- Blisters less tense ‘bubble-wrap’
- Can involve palms and soles, mouth ulcers rare
- Preceding diarrheal illness
- Send swabs/stool
- Conservative management
- Refer if not sure same day



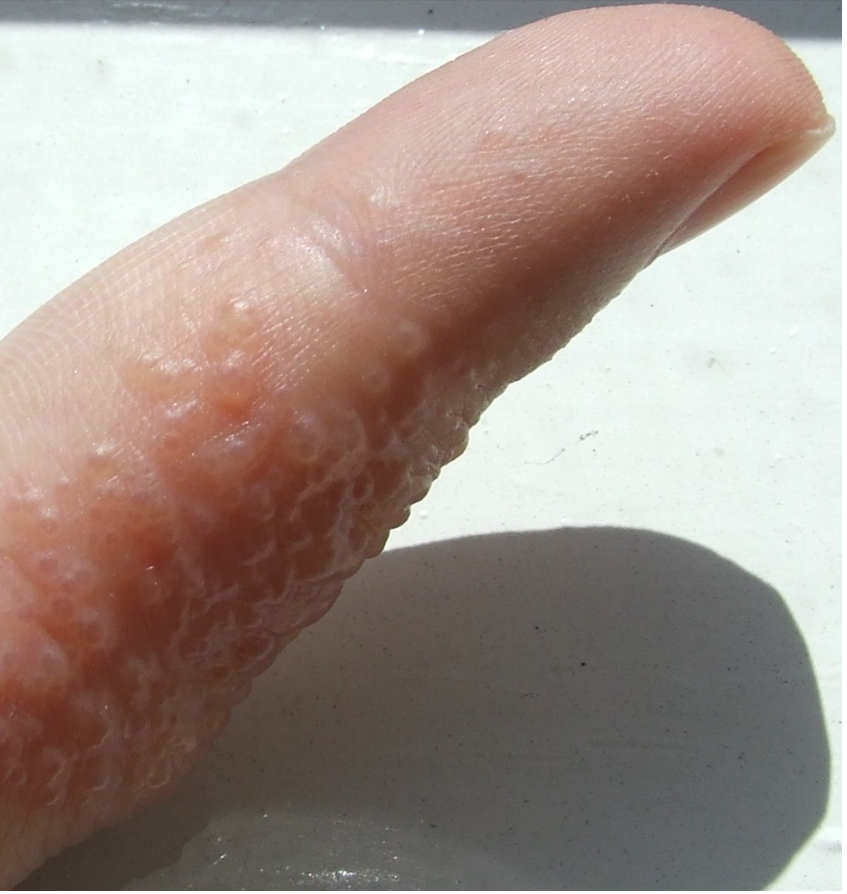
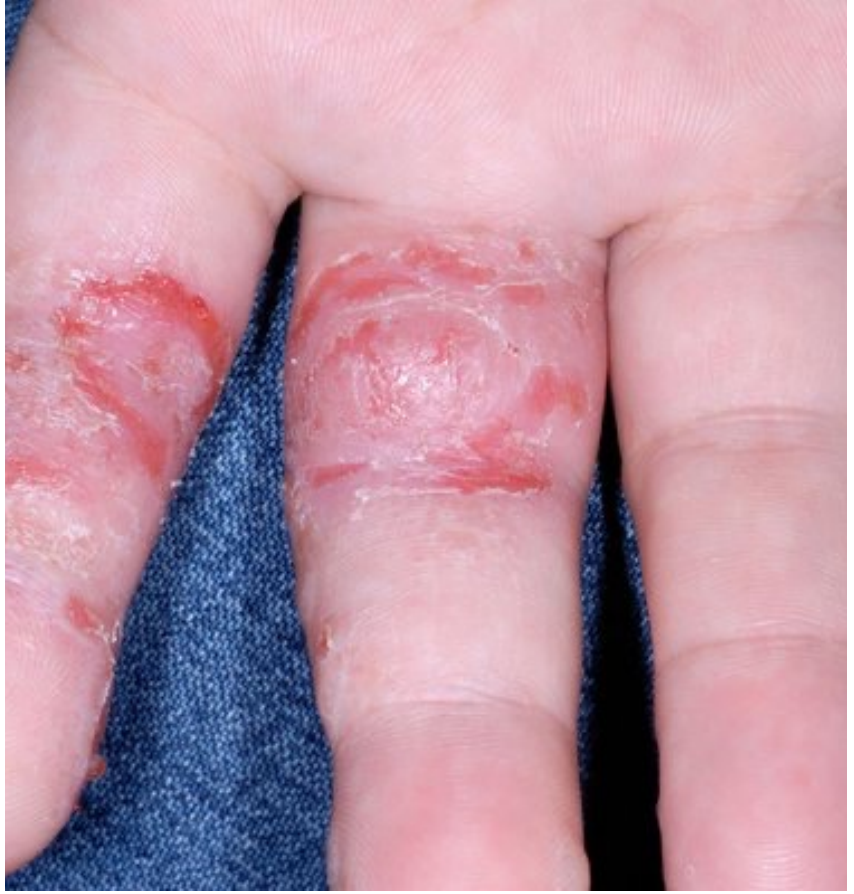
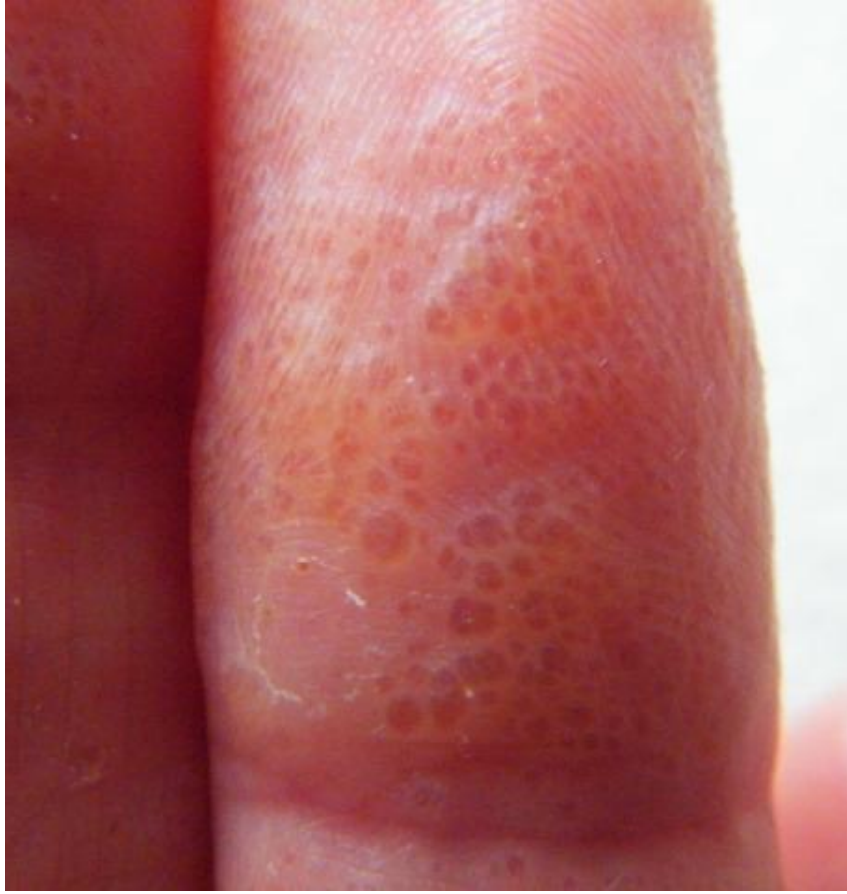


Other variants of eczema

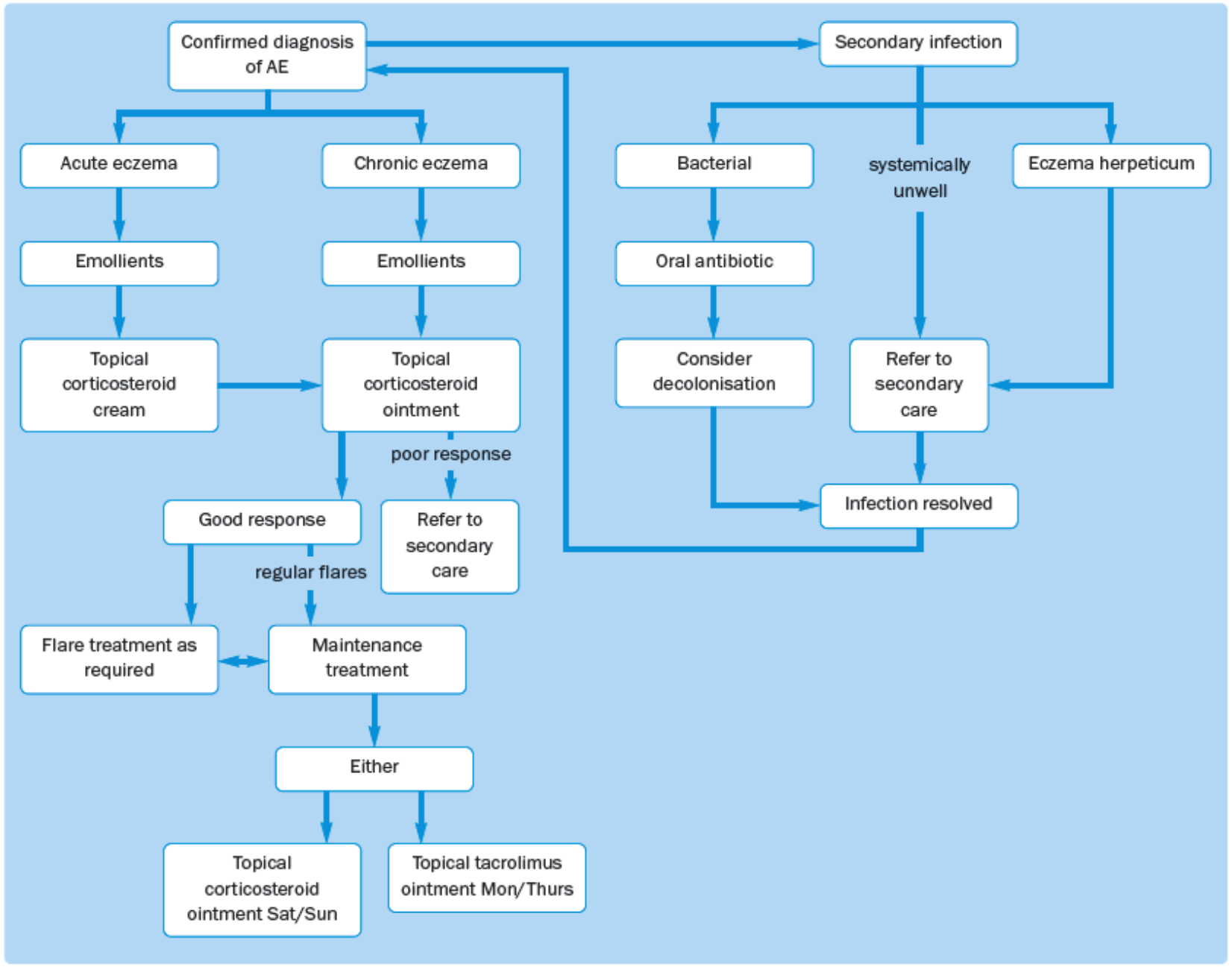




Discoid Eczema

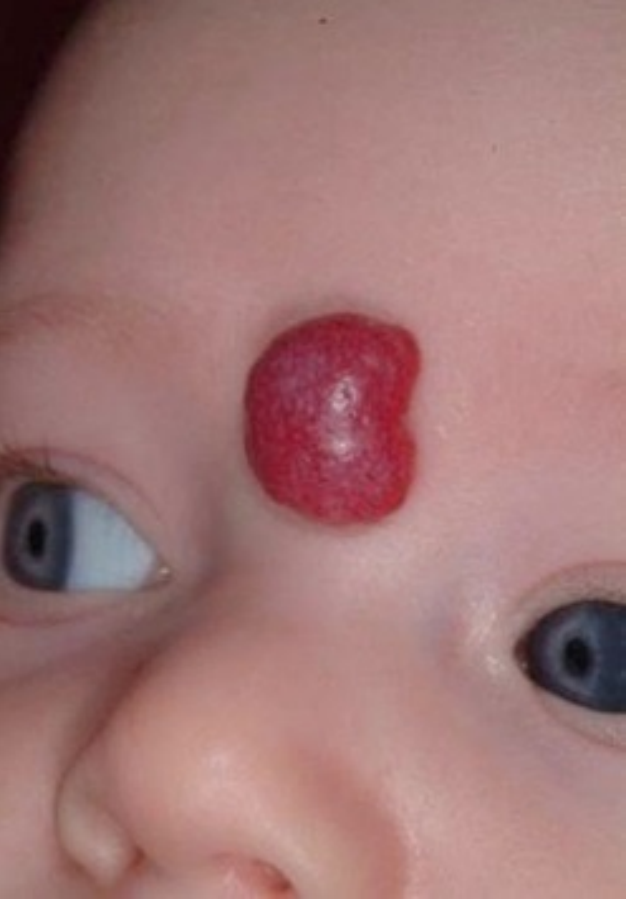




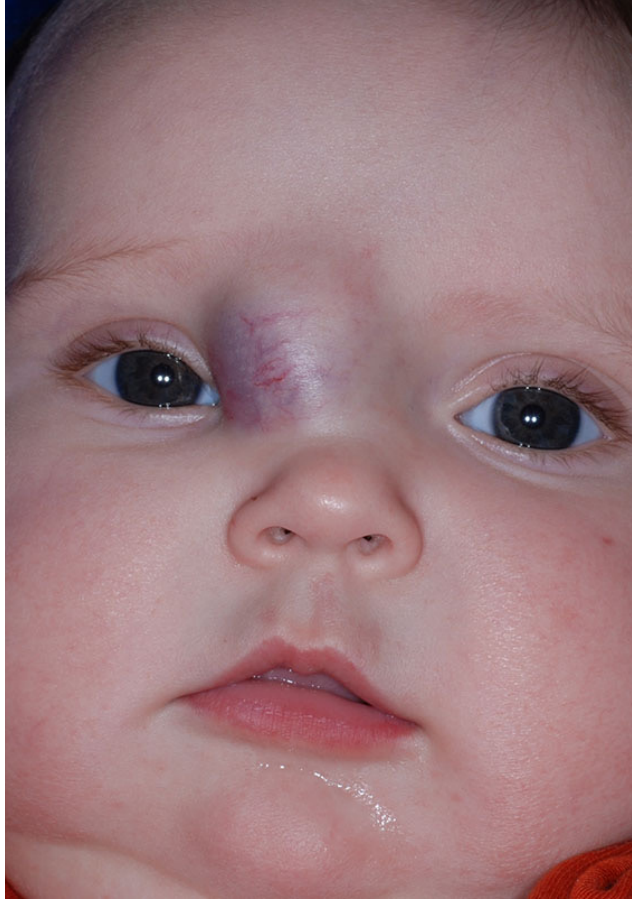
Pompholyx or Dyshidrotic eczema

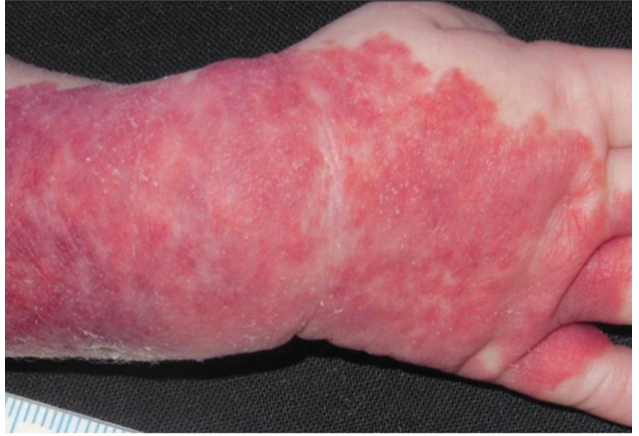


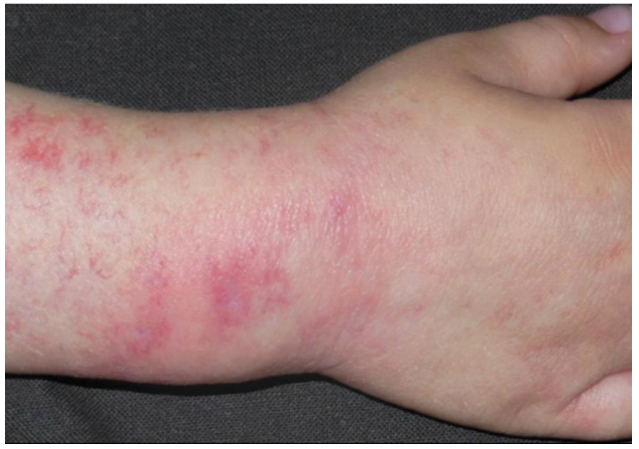
Referral pathway

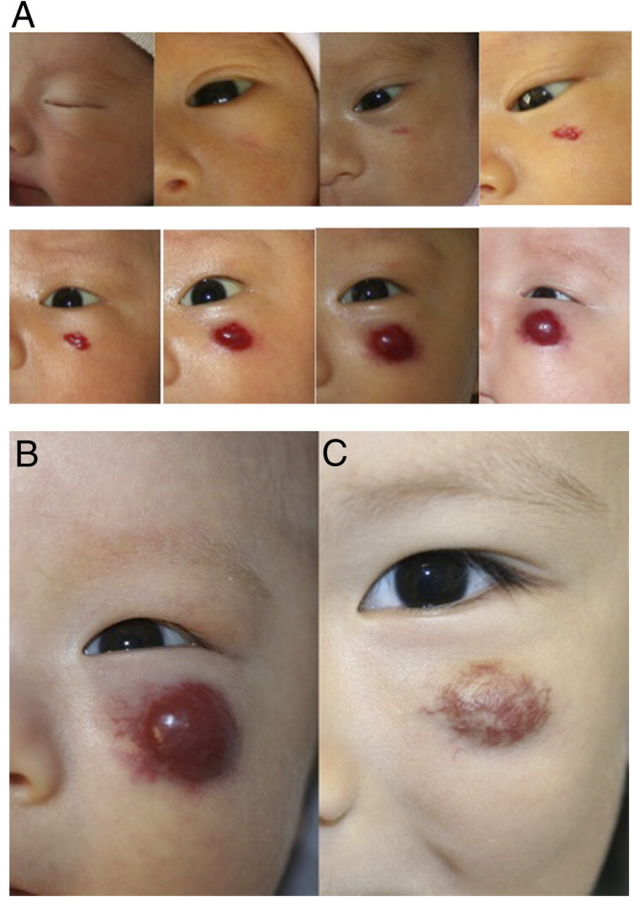
Infantile haemangiomas



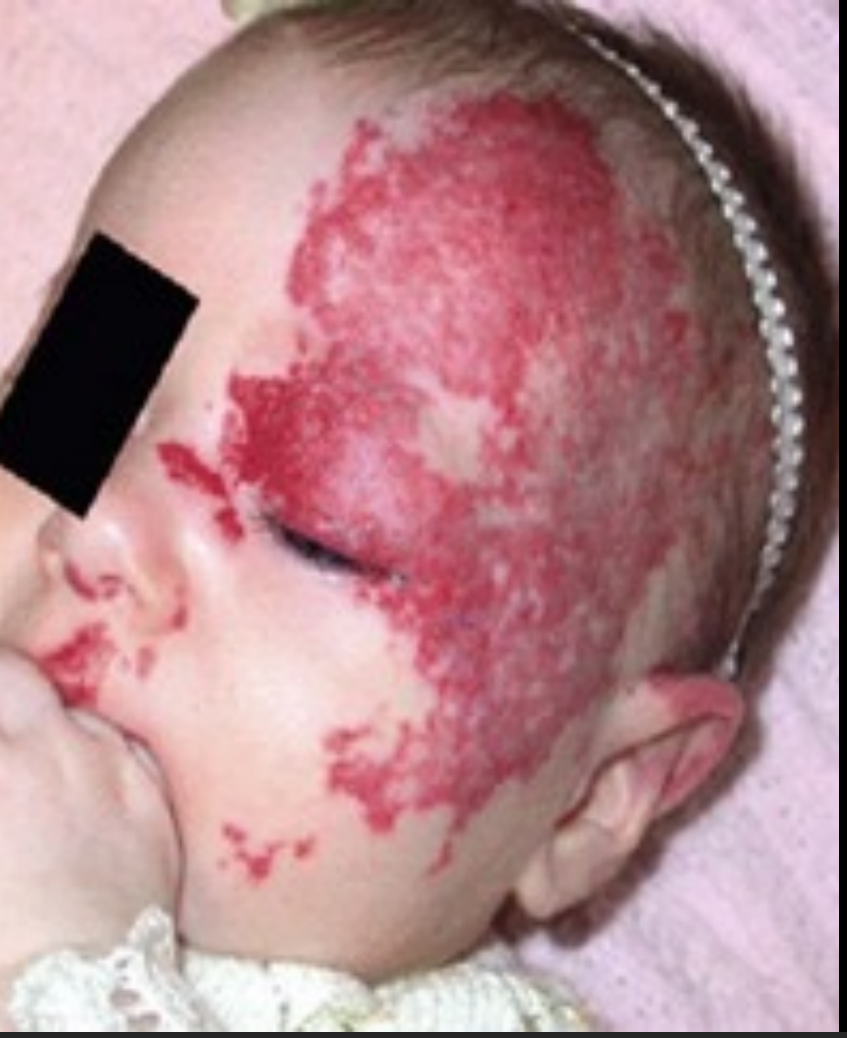


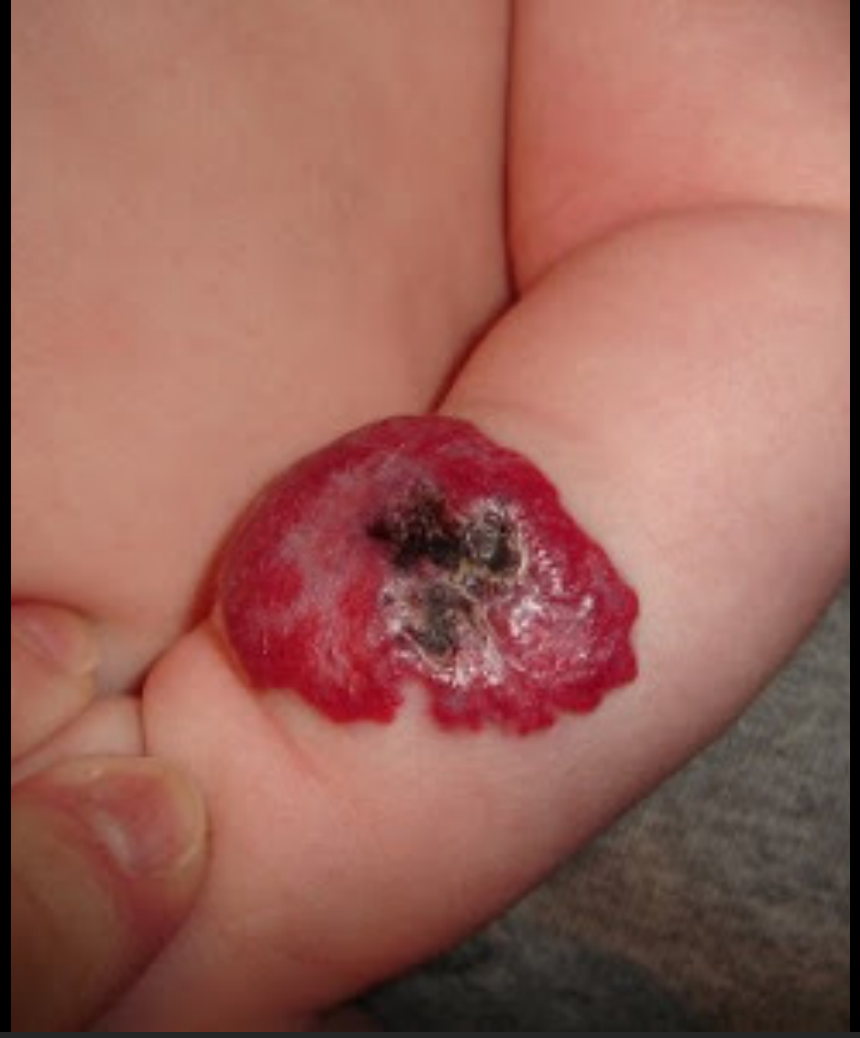


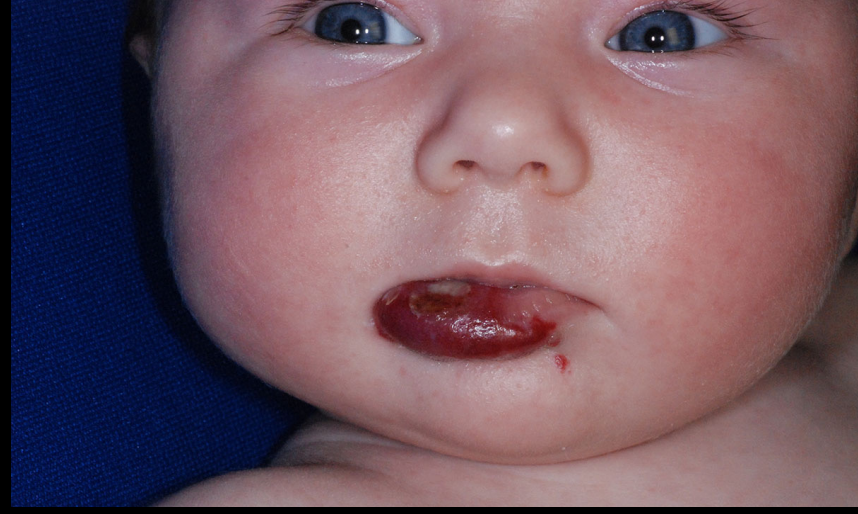


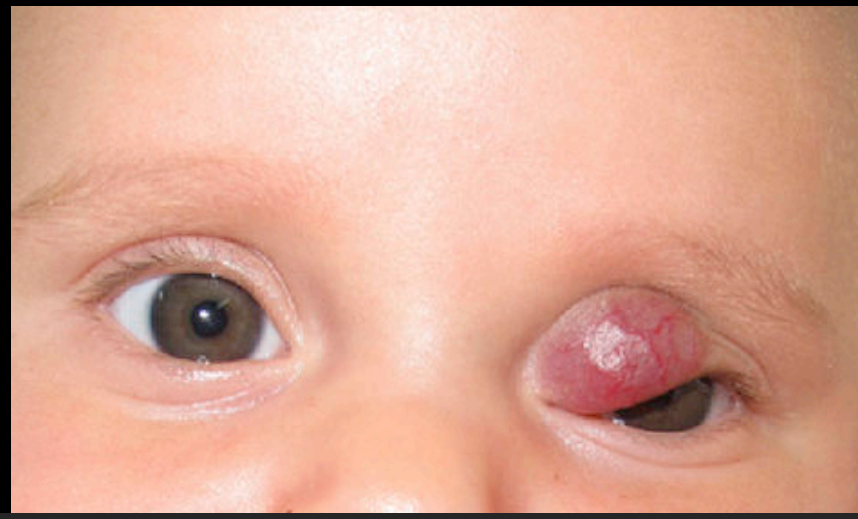


Infantile haemangiomas





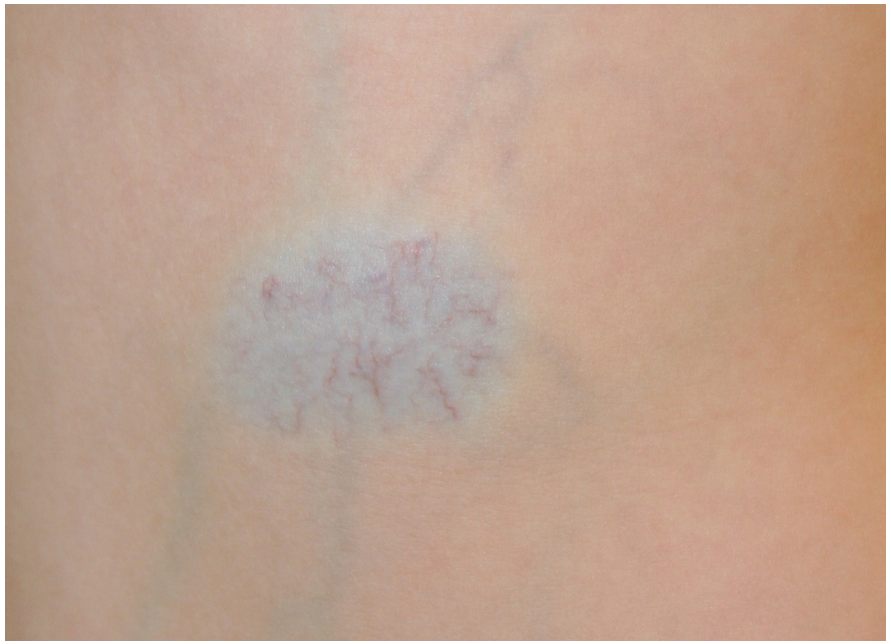


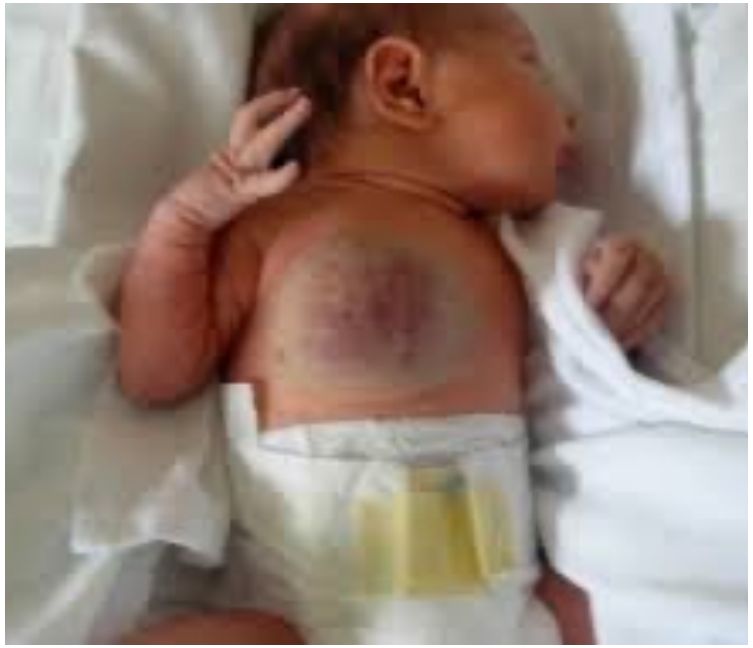


When to refer

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





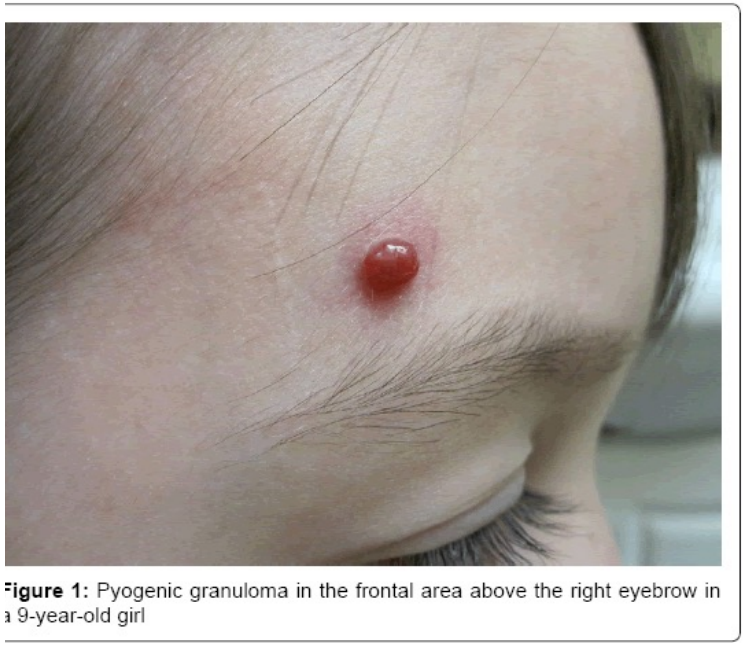
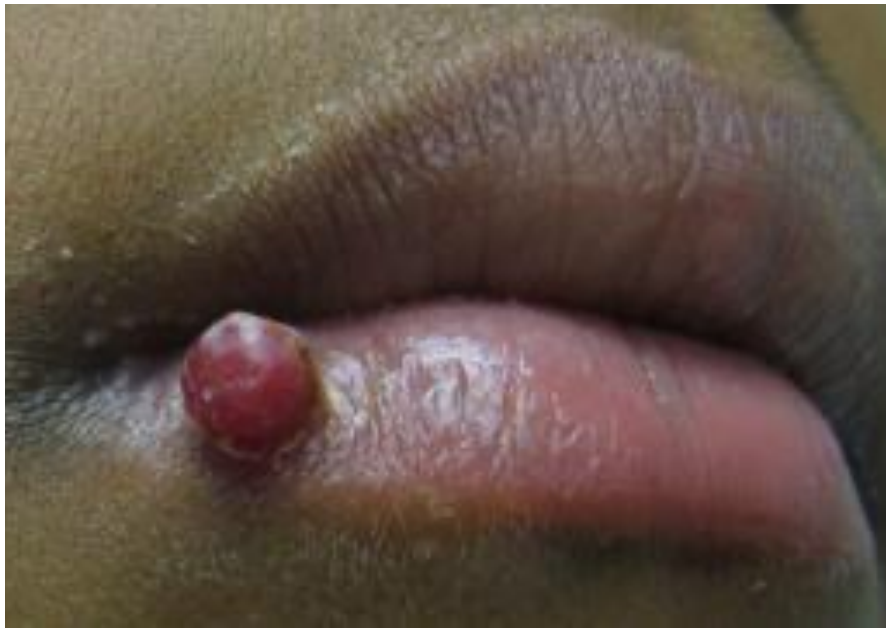


Figure 1: Pyogenic granuloma in the frontal area above the right eyebrow in a 9-year-old girl



These are not infantile hamengiomas!

Summary

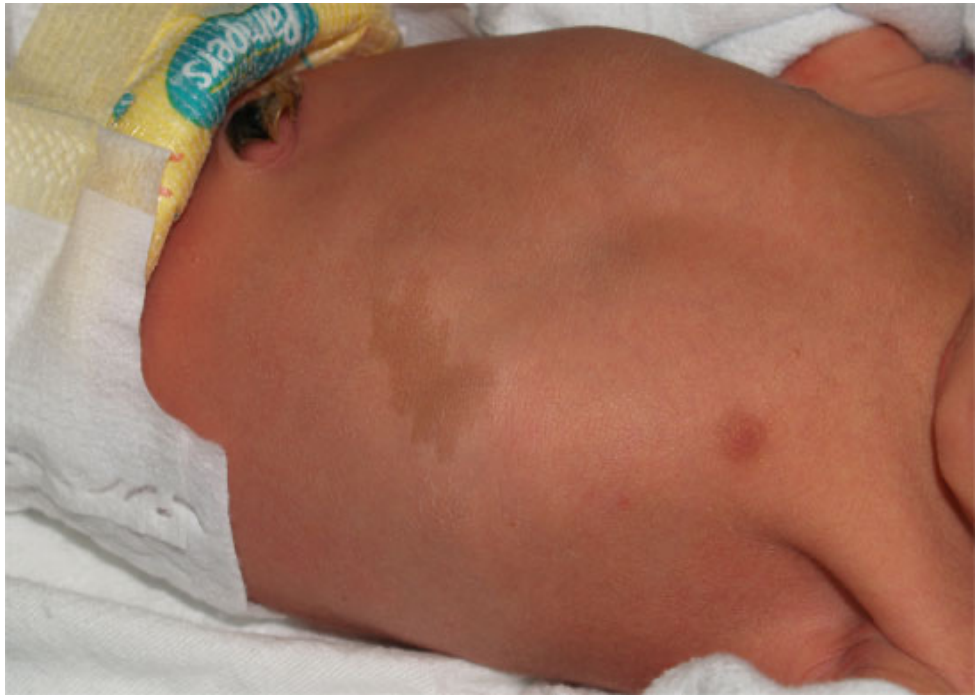
- Skin conditions often cause a lot of anxiety
- Most can be managed easily and with reassurance and education
- If not sure, seek advice from dermatology team, usually very accessible and amenable to photo consultations
- Know your local stock

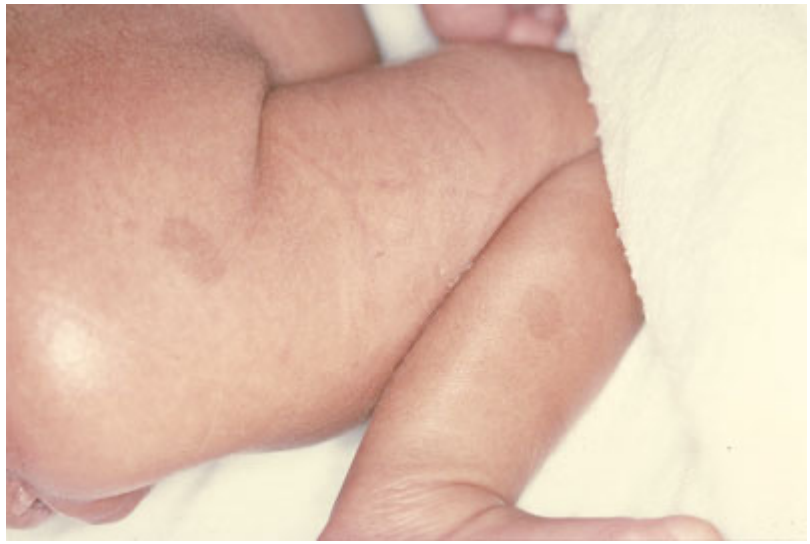
References

- 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 hamengiomas 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.

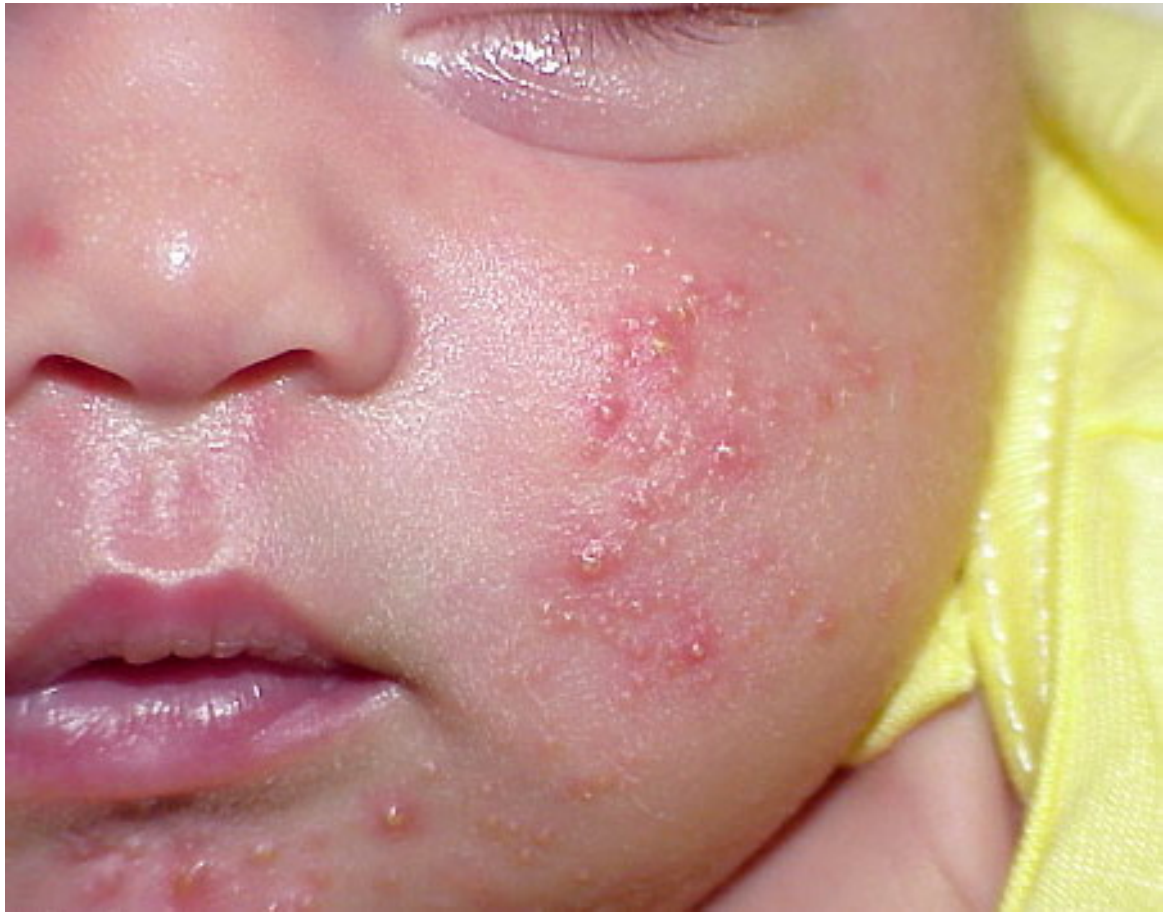
Other common rashes

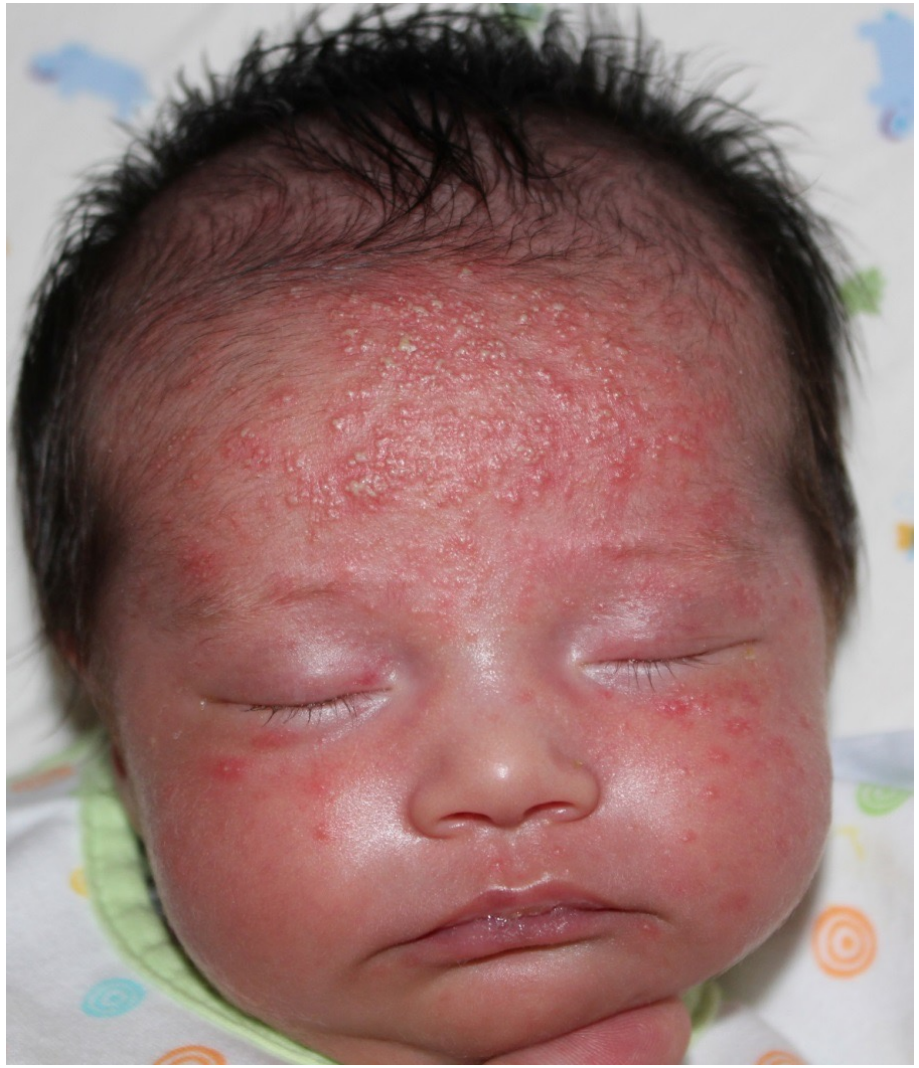
Café au lait macules



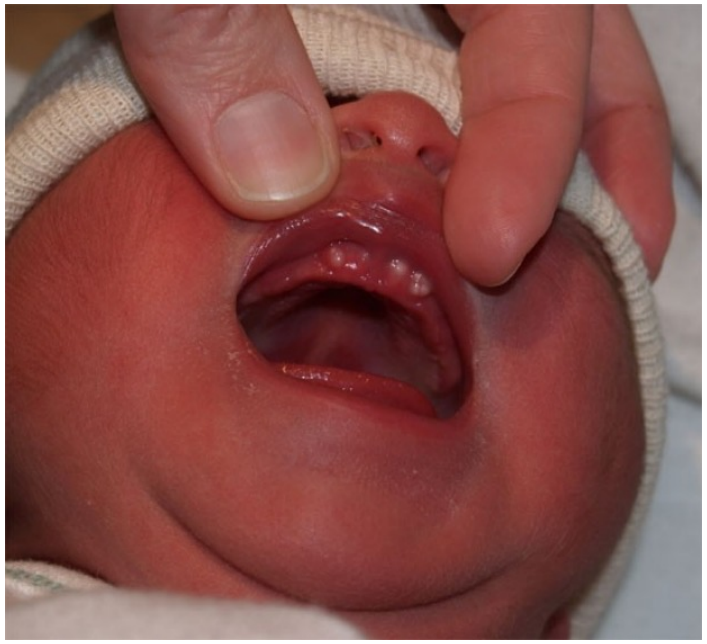


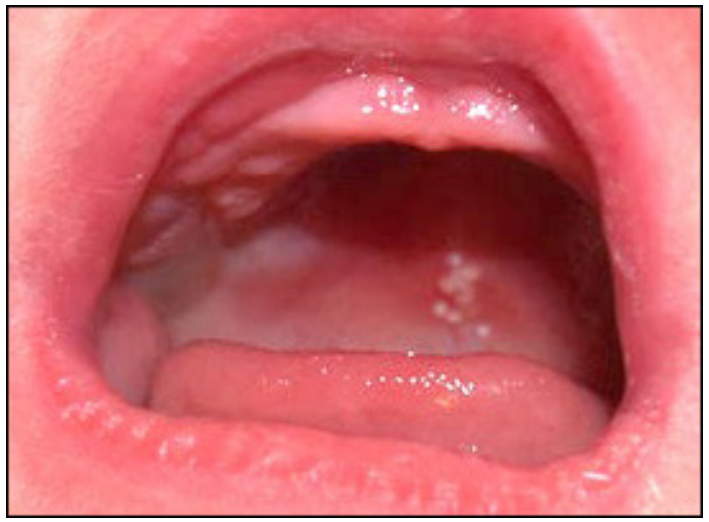
Acne neonatorum

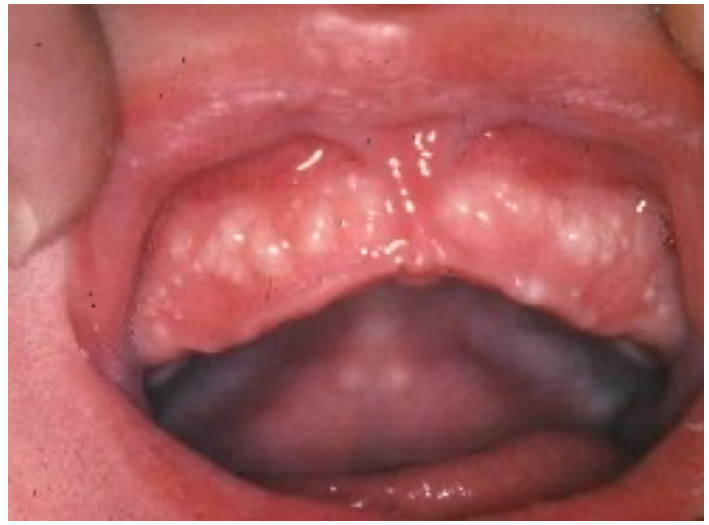




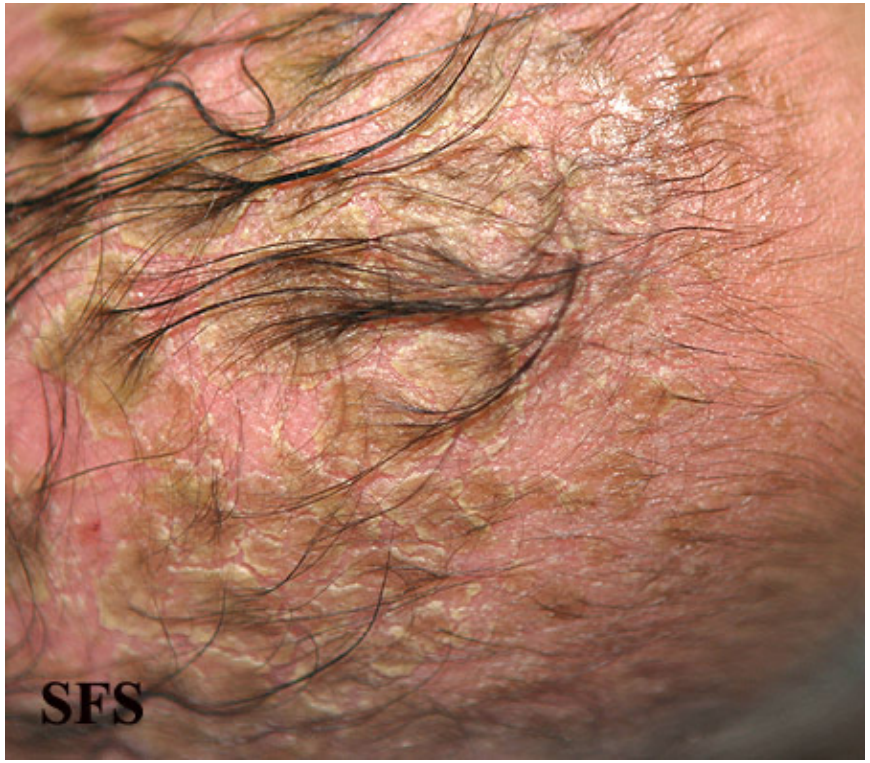
Neonatal cephalic pustolosis

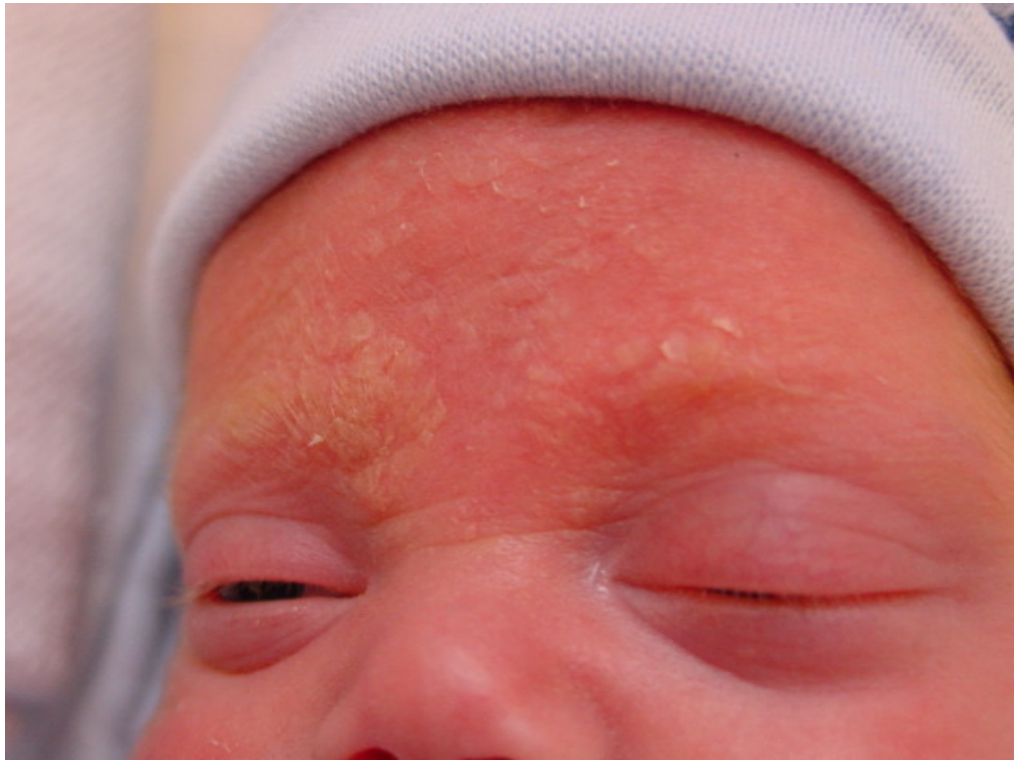






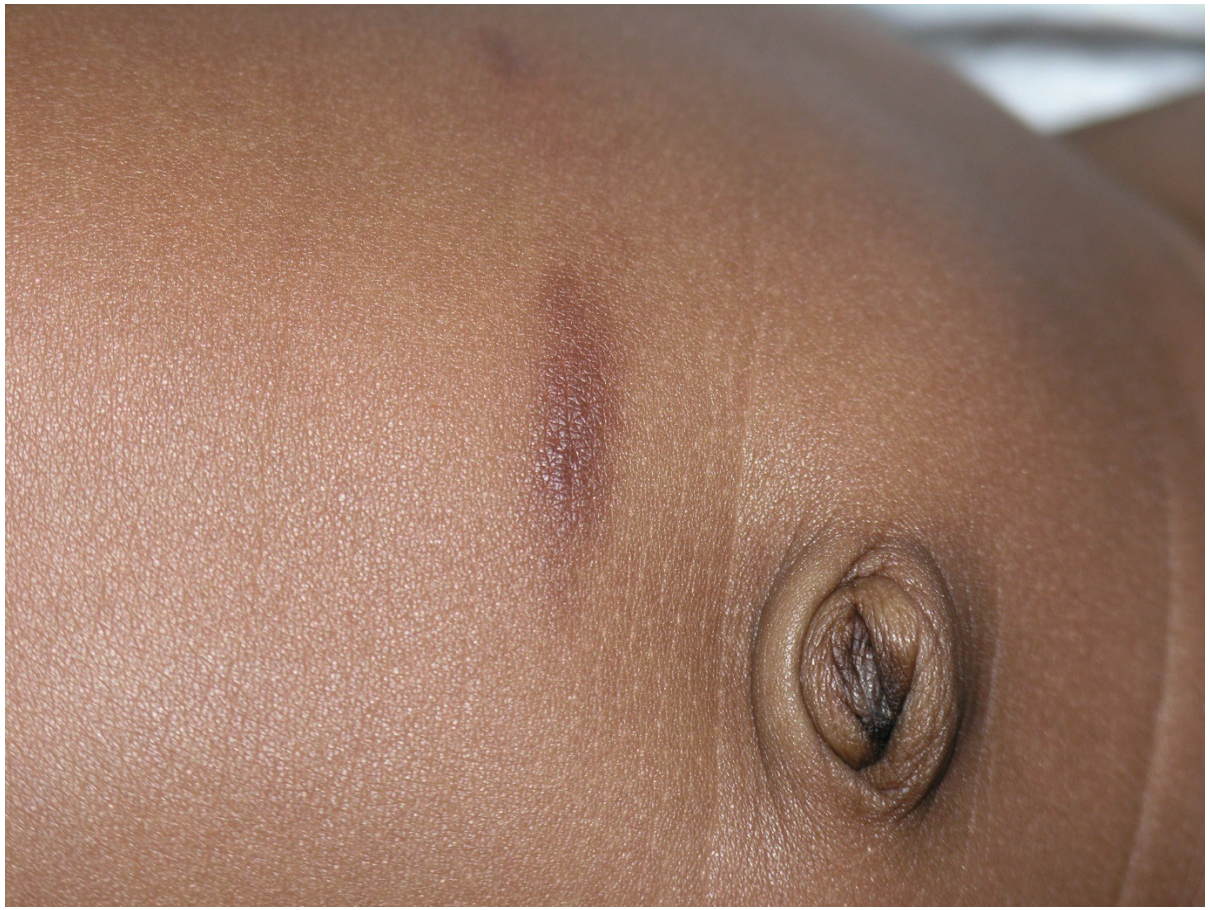
Epstein’s pearls/Bohn nodules

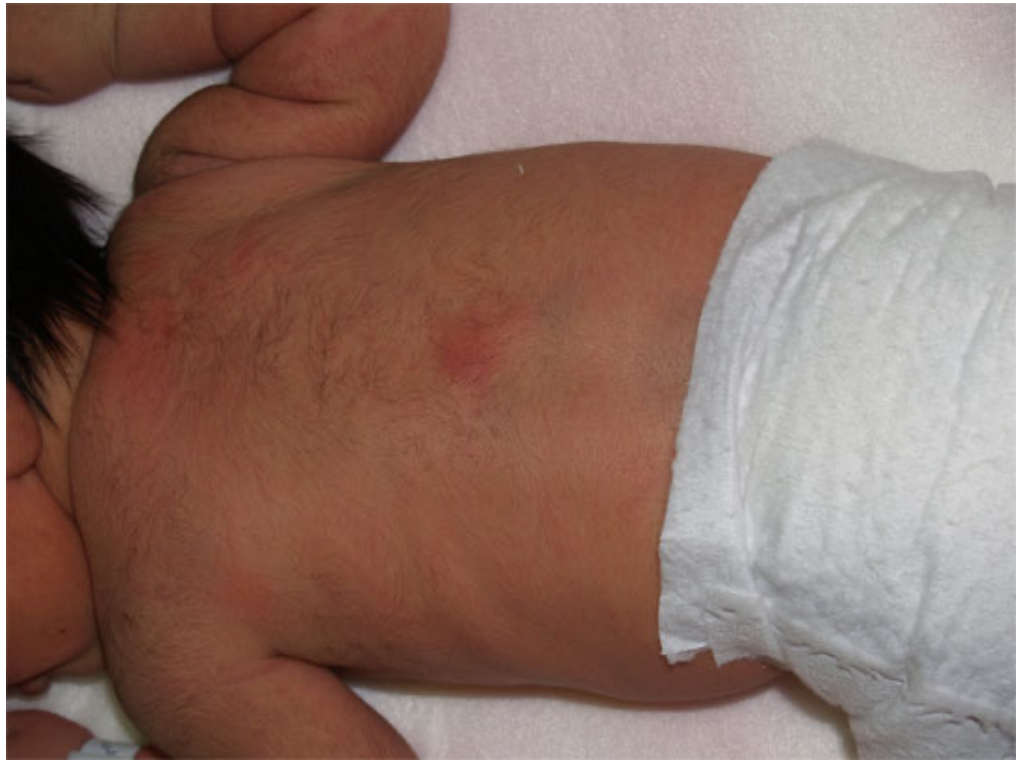


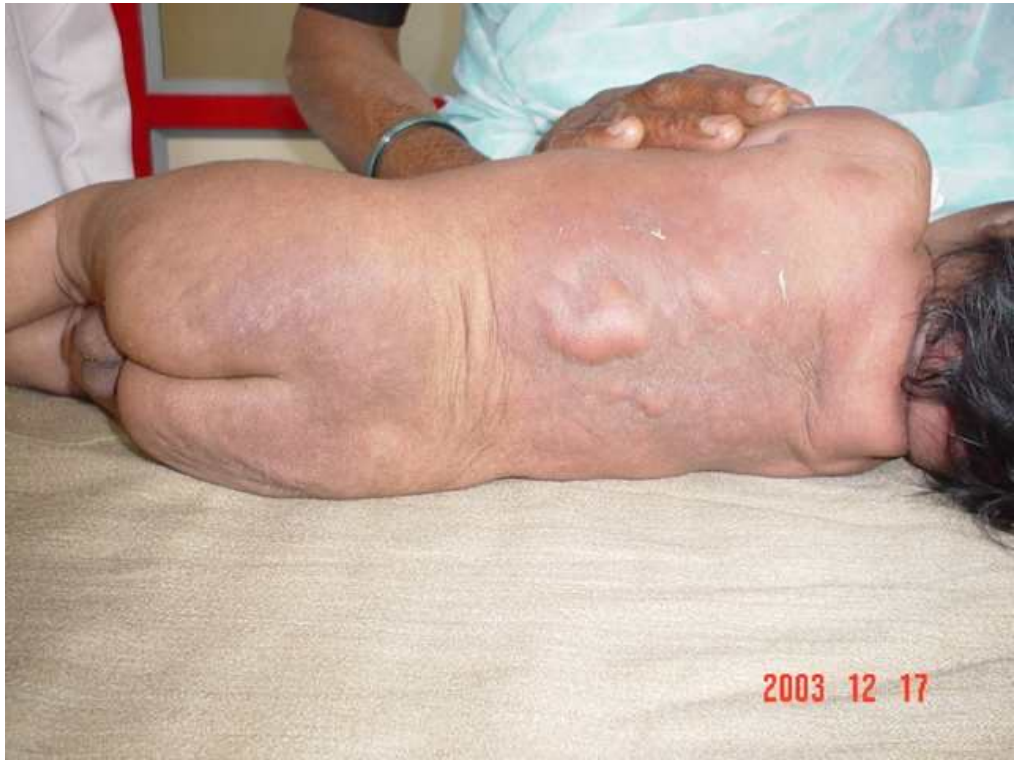


Seborrheic dermatitis

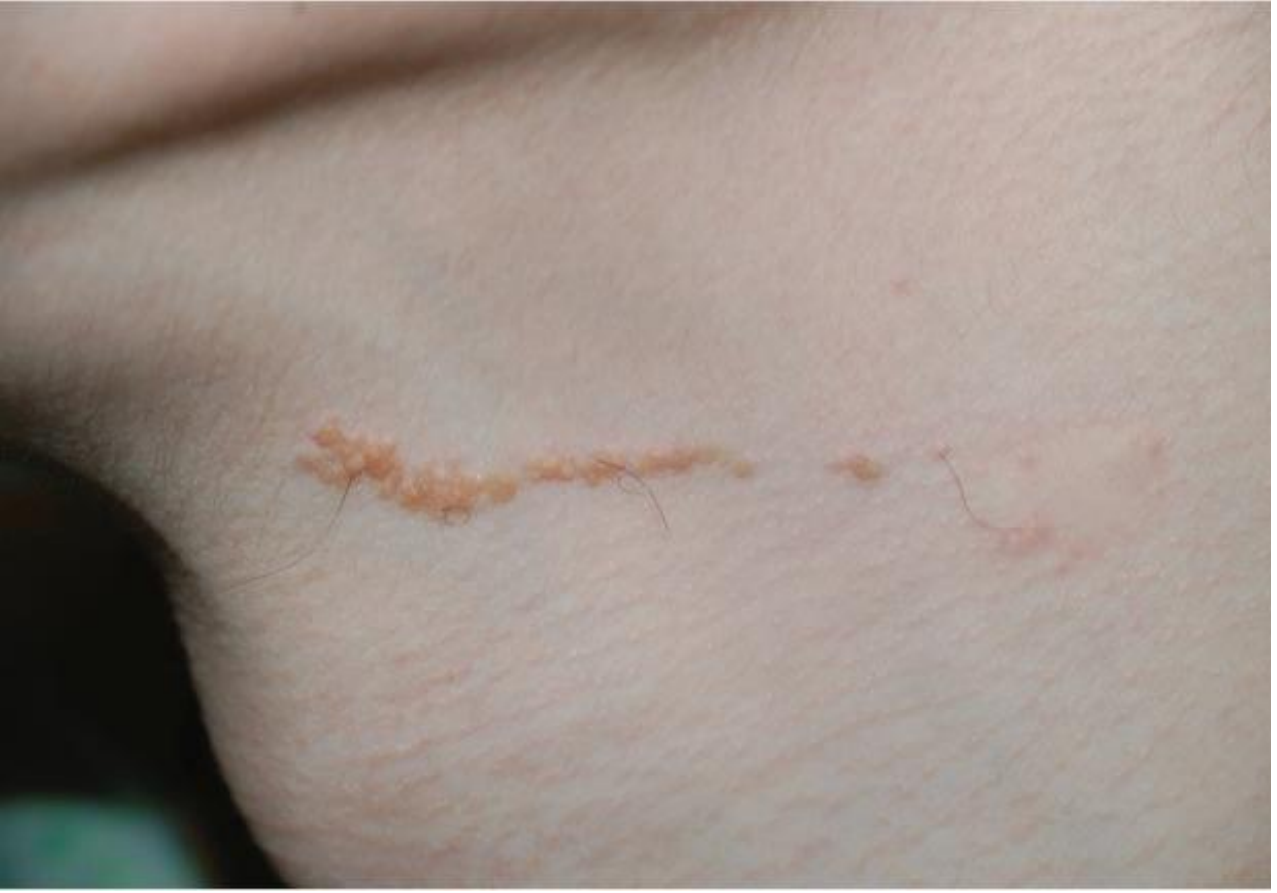
Mastocytoma

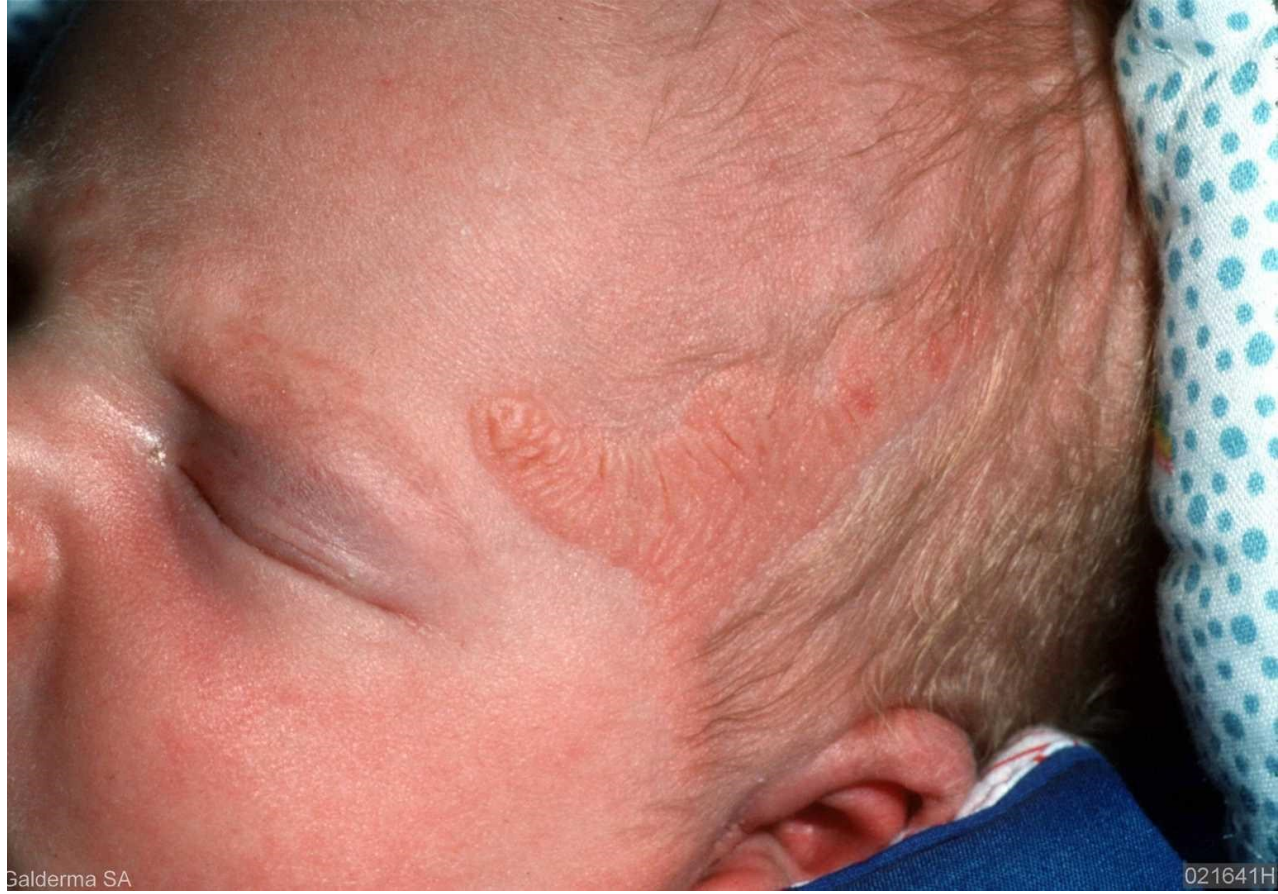




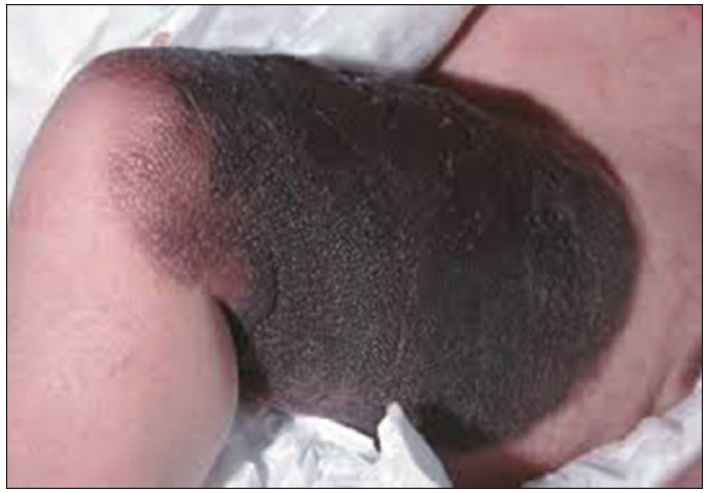


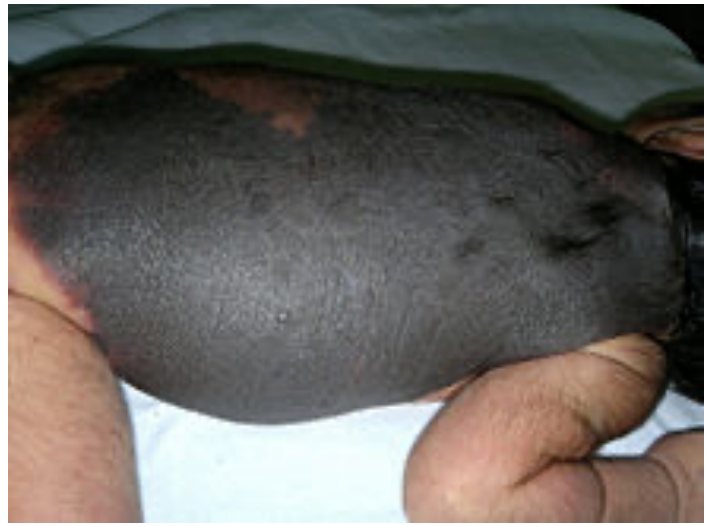
Subcutaneous fat necrosis





Epidermal naevi





Congenital melanocytic naevi