Postal Registration No. TN/CH/(C/59/2020 - 2022
Registered News Paper Posted at Egmore R.MS. Patirika Channel.
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RNI NUMBER : TNENG/2004/14197
RDISNo. 6342/98

Medi Quest BRS Hospital

A monthly News letter from BRS Hospital

PEARLS IN PAEDIATRIC DERMATOLOGY FOR THE PRACTIONER

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Price Rs. 5/- Only

March - 2020

Medi - 25

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Yearly Subscription

Rs 50/- only

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If you have not heard about **Prof. Partrick Yesudian** then you have not seen a patient with a dermatological problem. At some point of time one would have been forced to refer a patient to him. 20 years ago one month was waiting time for an appointment to see him. Today one has to wait one month to get an appointment to fix an appointment. The reason for his phenomenal success is due to a judicial blend of academic knowledge, clinical acumen, and practicality. A distillate of his experience and wisdom is evident in this news letter. This news letter is a collector's item we strongly urge you to preserve it.

Note :- Trade name of drugs have been mentioned keeping the practioner in mind and must not be construed as endorsement of these Drugs.

Commonly seen Dermatological Conditions in Pediatrics

1. Intertrigo & Diaper Dermatitis
2. Perianal excoriation
3. Seborrhic Dermatitis
4. Fungal infection groin
5. White patches over face
6. Insect bite allergy
7. Urticaria Acute, Chronic
8. Acne

1.Intertrigo and diaper dermatitis

Management of Intertrigo and Napkin dermatitis is somewhat similar. Both present as bright red rash of the inner thighs and buttocks ie., Nappie covered areas but in napkin dermatitis the inguinal and gluteal folds are spared Should one use disposable nappies like huggies or the cloth ones ? No firm answer to this but in both frequent changes should be wrought because the ultimate irritant is either the acidic urine or liquid stool which remains in contact with the sensitive skin. There is often super added bacterial and candidial infection. The red skin is sometimes alarming to the parents but often is symptomless to the infant. I advise mothers to avoid nappies of any sort during the day time, Only if the child is taken out or at nights, nappies should be used and if possible changed as soon as it gets wet. A mild steroid cream at nights for a few days only -

Hydrocortisone 1%, Zempred, Lacticare HC 1% or Desowen are all low potency steroids. Total avoidance of stronger steroids at these vulnerable sites. If there is a superadded candidial infection, Micanozole or clotrimazole cream can be applied. For secondary bacterial infection T-Bact or Gentamycin creams can be used. Combinations are available like Lozee GM cream - can be used for a few days only, Quadriderm is a high potency steroid and should not be used in infants.

Should we use powder to keep it dry? I don't like the use of powder since the gritty particles formed after the powder gets wet can be Irritating. | prefer the use of moisturizing cream like cetaphil, atogla etc If the child has loose stools vigorous cleansing with soap should be avoided. I tell the mother to gently remove the fecal matter with cotton soaked in liquid paraffin and then run a little soap water to rinse it off. A barrier cream containing Zinc oxide (Siloderm) can be applied on that area to prevent skin contact with urine or fecal matter. For severe bacterial infection oral antibiotics to be given.,lf the child is disproportionately sick suspect systemic disease Histiocytosis, Kawasaki, Biotidinase deficiency etc

Intertrigo neck is treated along the lines of groin intertrigo. Here again the habit of mothers dusting huge quantities of tale powder should be discouraged. It is suggested that the inhaled talc could cause lung granulomas. Neck intertrigo often seen in obese children before the head becomes steady. The bright red color is often totally asymptomatic to the child but frightening to the mother. Note Some of these children could develop psoriasis later

1. Perianal dermatitis :

Perianal dermatitis is presumably due to an irritant dermatitis to fecal constituents thus may have an overlap with nappic dermatitis and intertrigo. Severe cases may show oedema and erosions, healing however occurs in a few weeks.

Treatment => similar to Intertrigo. Frequent applications of emollients would suffice.

Note : Make sure there are no developmental anomalies in the anus. In older children with bright red erythema over the buttocks " the baboon syndrome" should make on elicit a h/o oral drugs like Amoxycillin.

2. Seborrhic Dermatitis Scalp

Popularly called the cradle cap. In the early weeks considered to be persistence of vernix. But after that it may be a true dermatitis because it can affect the eyebrows later the temples and forehead. Simultaneously the intertriginous folds can be affected to be differentiated from atopic dermatitis. The latter commences after the 3" month and is intensely pruritic. In very sick children consider Histocytosis and Wiskott Aldrich and other immuno deficiency syndrome.Management soak with olive oil or liquid paraffin for several hours and then rinse off with a baby shampoo. In severe cases I advise Nizral blue 1% shampoo twice weekly and when rinsing to avoid getting it into the cye .Cradle cap spontaneously remits after the 6th month.

3. Fungal infection:

Fungal infections of groin is rare in children but on the scalp it is a prerogative of children. For limited

infections topical antifungals would suffice: Terbinafin, Fluconazole, Clotrimazole to be continued for 2-3 weeks. Source to be treated - usually one of the adults at home women in the waist region and men vver the groin.Systemic antifungals like griseofulvin and Fluconazole only for scalp involvement. Dosage in children Griscofulvin 15mg/kg/day for 6-8 weeks in two divided doses. Fluconazole 6mg/kg/day for 6-8weeks, Terbinafine 3-4mg/kg/day for 4-8wecks.

4. White Patches:

White patches on the face of children presents a huge differential diagnosis. But the dermatologist is worried about only 2 conditions Hansen and vitiligo. The latter of course in a few-weeks will get totally depigmented. Regarding. Hansen testing for sensations is a wasted effort in children; biopsy, which may help, is often refused by the parents. So an approach of watchful expectancy should be adopted. The vast majority of other conditions which give hypopigmented patches like. Pityriasis, alba, Tinea versicolor, Photosensitivity, contact dermatitis and Pityriasis Rubraa Pilaris are all transicnt lesions which come and go but Hansen's will be a persistent patch. Worms causing white patches is a myth. Management I first remove all irritants like soap, perfumes, powder, creams etc. A sun screen if the child is Swimming or indulges in outdoor activitics. Mild steroid vide supra for a few weeks, moisturizers at nights and if there is definite photosensitivity hydroxychloroquine for a month in low doses. If the patch & persistent in spite of all this then I suggest Multidrug therapy Dapsone with Rifampicin for 3 months and watch the response. If the patch has disappeared, complete 6months of MDT

5. Insect bite allergy

Insect bite allergy In my reckoning only 2 things will help'- Time and protecting the skin against bites. It should be explained to the parents that it is not the bite itself but an allergy to the bite, which causes the itchy papules over exposed skin. Otherwise they will argue that other children are not affected. Secondly I tell them that mosquitoes are only one species which causes IBA. A host of others like mites, ticks ete in the environment can also cause this. So once the patents have understood this | ask them to stitch pyjamas and jubbha which should be put on by 5-6PM and removed only in the morning, since theyare active in the day, insects are less likely to bite. If the parents do not comply with this I refuse to treat the patient. Treatment is only symptomatic. For infected IBA Flutibact is ideal at nights. No potent steroids should be used. For itchy papules, Anthical or Sama lotion will relieve the pruritus, At nights an antihistamine can be given. If the lesions are impetiginised an oral antibiotic to be given to avoid glomerulonephritis through streptococcus. Usually the condition remits after 7years or if the patient moves to a new location but in atopic children and children on immunosuppressives or lymphoreticular disease the condition may persist indefinitely.

6. Acute urticaria :

Acute Urticaria in children, in the vast majority is

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caused by infections either viral or bacterial. There is often a history fever with URI. So I usually do a TC, DC. If the total count is increased with a predominence of polymorphs I start them on an antibiotic preferably Macrolides like Roxid since it also is immunosuppressive. If the counts are normal I presume it is a viral and wait for it to take its course. In the meantime the most important therapy is Antihistamines, the dose should be repeated every 6 hrs to maintain sufficient blood levels to block the histamine which is being released. Often Doctor's give one shot of Avil the lesion subsides every body is happy but in 4hrs the wheals are back. The antihistamines should be gradually tapered off over 7-10 days as the urticaria subsides when the infection is controlled. Systemic steroids have very little role to play except as a single IM shot of Betnesol or Decadron - morcto allay the anxicty of parents. Because oral steroids will further aggravate the infection and perpetuate the urticaria they are best avoided. In atopic children, food particularly peanuts and sea food can trigger off acute urticaria, Deworming for urticaria is mostly a myth. Except in Qwinke's Hereditary Angioedema, laryngeal obstruction is unusual in Acute urticaria in normal children. Adrenaline S/C can also be given for immediate effect until the antihistamine takes over. Chronic urticaria is rare in children but when if does occur therapy poses the same problem as in adults since the cause can be found in less than 25%. In chronic urticaria one is justified in doing hunting for a cause_ motion, focal sepsis cte.

Note : Mastocytosis may present as chronic or recurrent urticaria.

7. Acne :

Acne is usually not a major problem in pediatric practice. But there is a small group, particularly female children who start developing Acneiform eruption even by the 9* or 10° year the so called prepubertal acne since the hormonal surge occurs in girls well before the menarche. When it occurs at this early age parents should be reassured that it is only a physiological phenomenon. Since we can do nothing about the hormones, treatment is directed towards other factors, sebaceous gland hypertrophy, follicular occlusion and infection with P.acnes. Mostly topicals would suffice Deriva C gel is an ideal application - it should be dabbed on and not rubbed at nights. Other application that can be used are Nadoxin gel, Cindac A solution, Acnesol lotion + Benzac Ac gel. Different patients prefer different externals – we can leave it to their choice. Dandruff should be controlled. No cosmetic should be allowed until the child crossed the 19" year and this goes for procedures like waxing, threading ¢etc.Number of acne soaps are avoidable but I prefer the old Cinthol soap. 3 washes per day is mandatory. | don't put too many restrictions on diet but I am strict against the use of cosmetics of any sort and also against meddling with the pimples. If there is a premenstrual flare and there are inflammatory lesions then a 2-3 weeks course of antibiotics Doxy, Azithro or Monocycline can be given. The ultimate aim of Acne treatment is not to prevent fresh lesions which is well nigh impossible but to prevent eventual scarring. If we allow scars to appear them our treatment has been a failure. Systemic retinoids are sometimes required for teenagers with Gr 3 or 4 Acne, Its prescribing is best left to Specialists because of the side - effects.

Owned and Published by Dr. Madhusudhan 28, Cathedral Garden Road,Chennai - 34.
Printed by S. Baktha at Dhevi Suganth Printers 52, Jani Batcha Lane, Royapettah, Chennai -14.
Publication on : Final Week of Every Month Posted on 15.05.2020