Common neonatal eruptions

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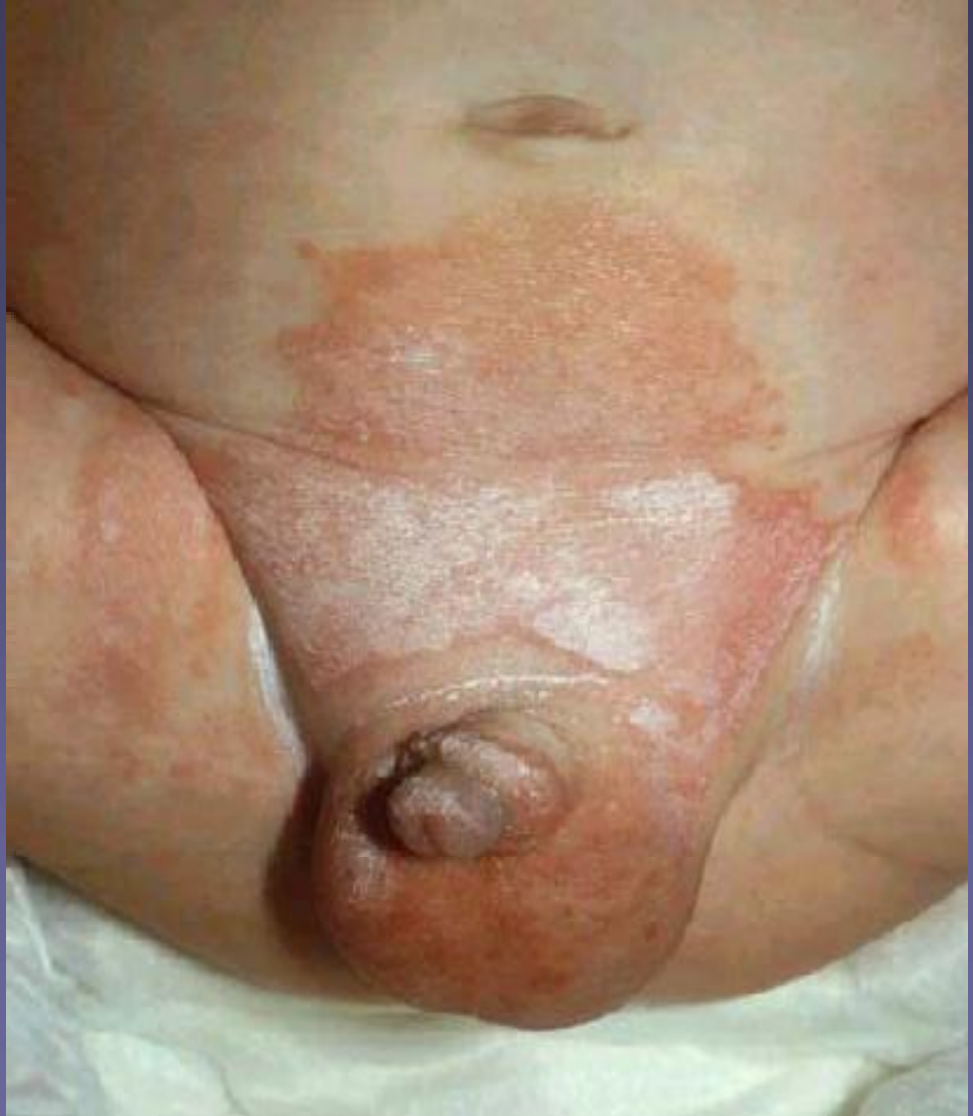
Nappy rash

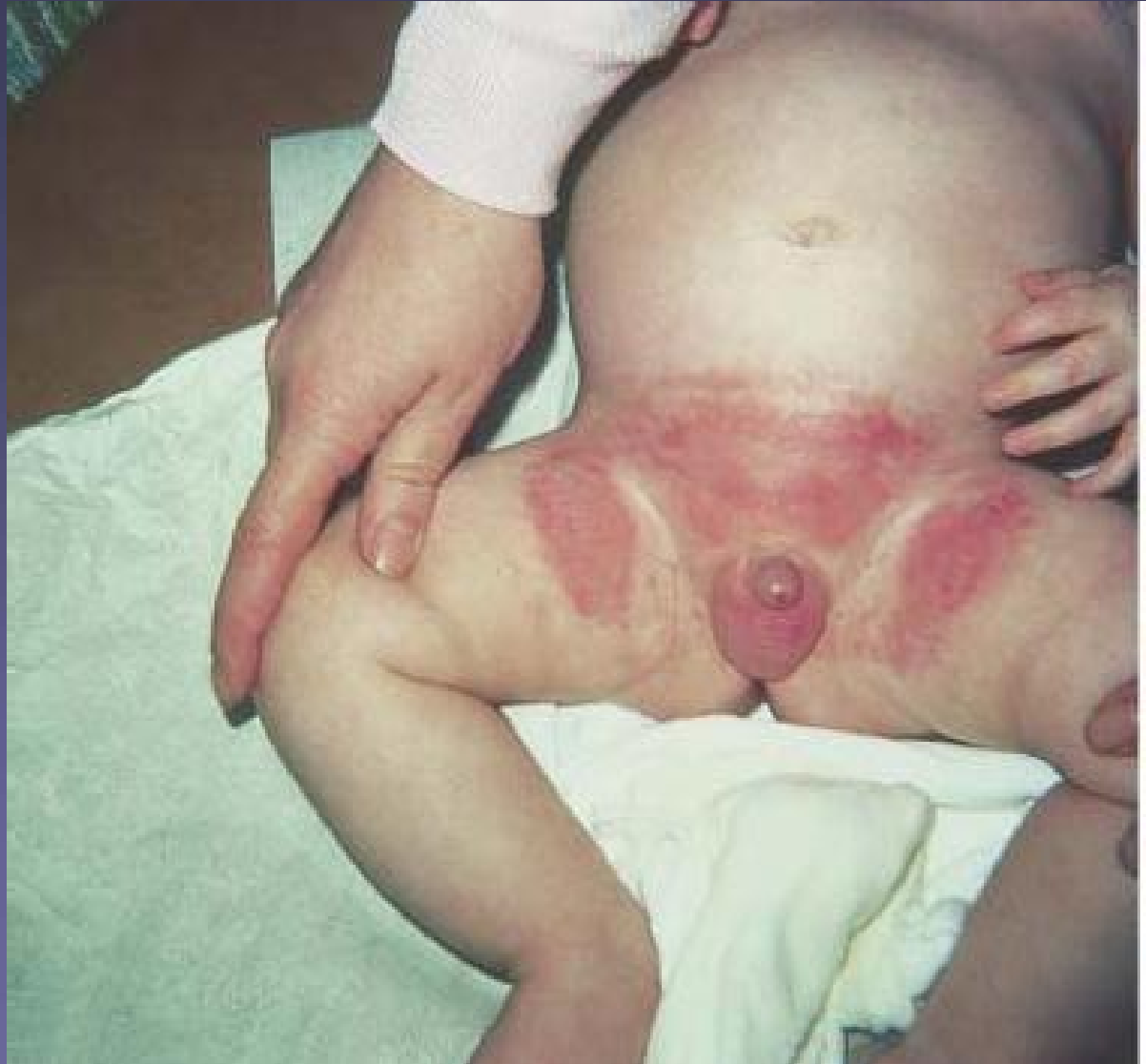
Nappy rash

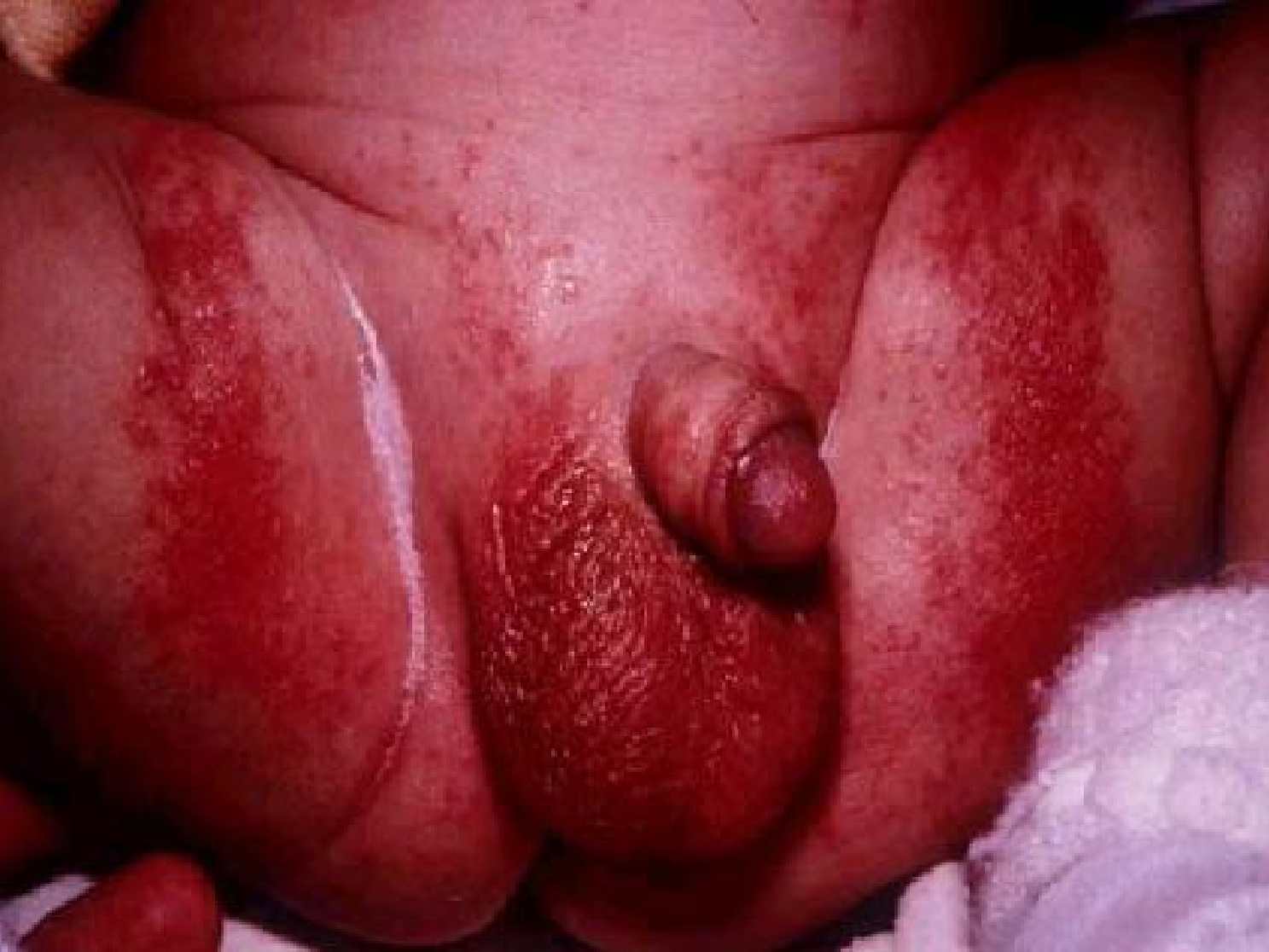
- Much less common now
  - Better disposable nappies
- Secondary candidal infection (thrush) much rarer

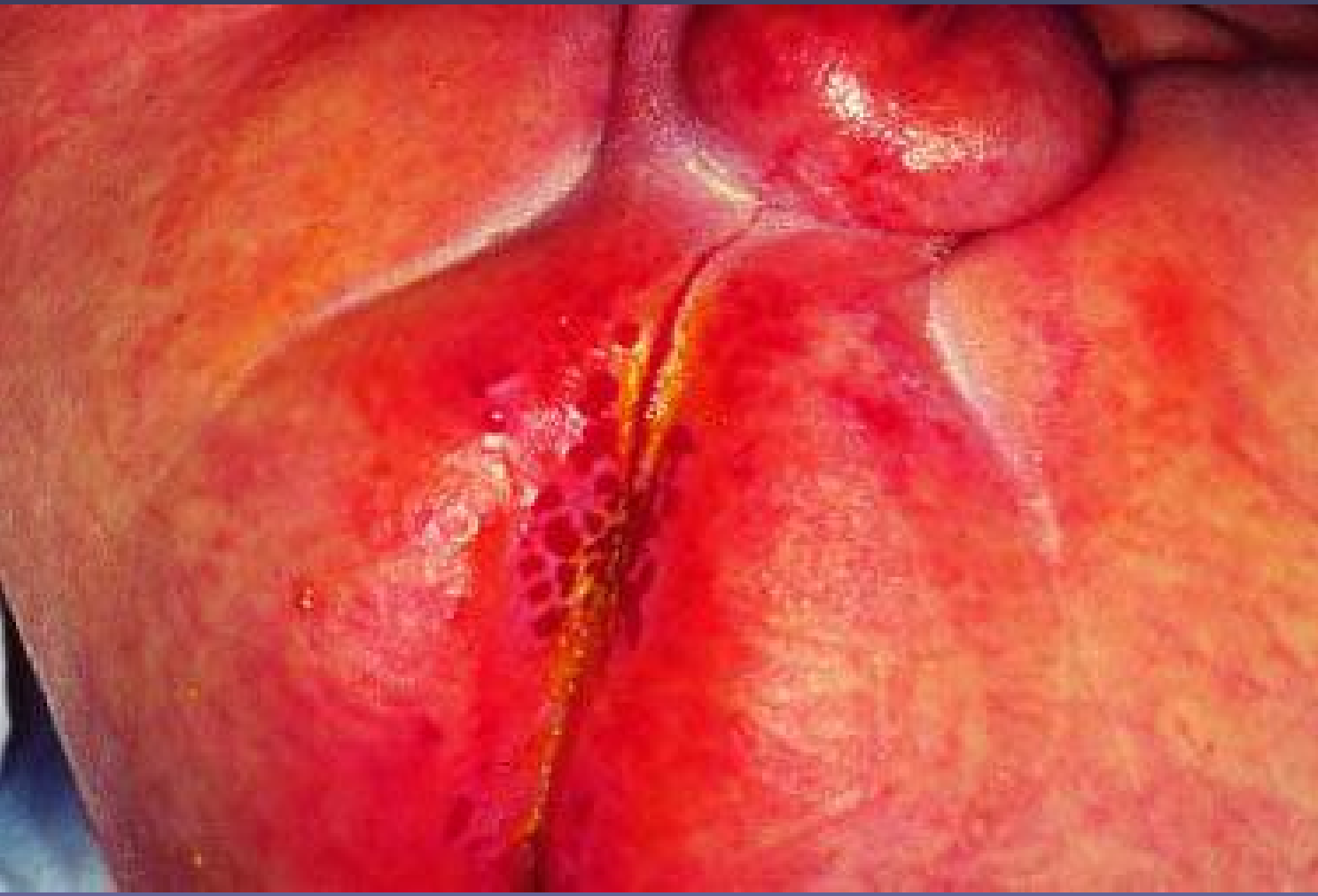
Nappy rash

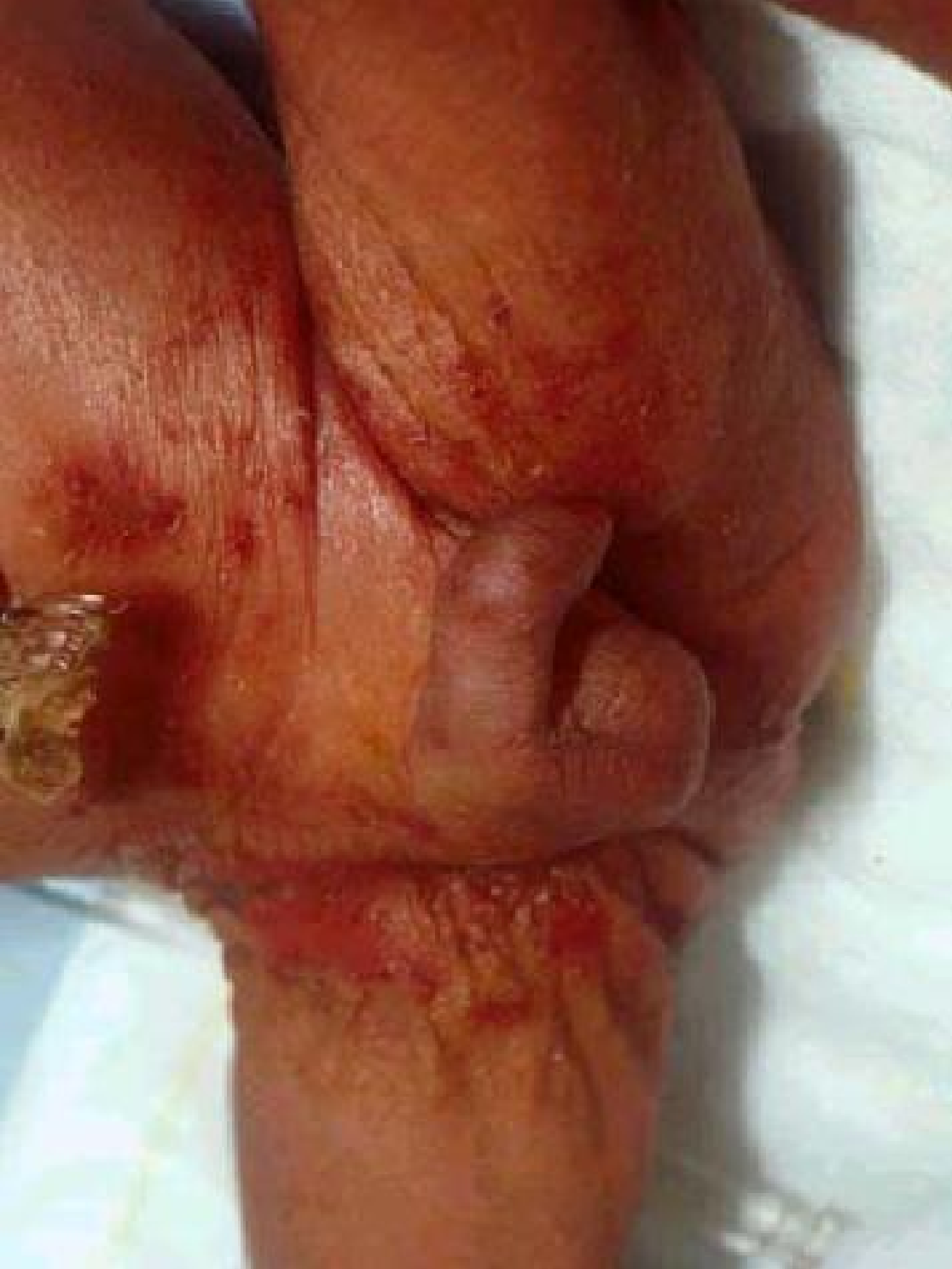
- Irritant contact dermatitis
  - Skin has a threshold of irritation
  - Combination of heat, occlusion, urine and faeces
- Once broken down, the natural barrier is disturbed as threshold of irritation is less

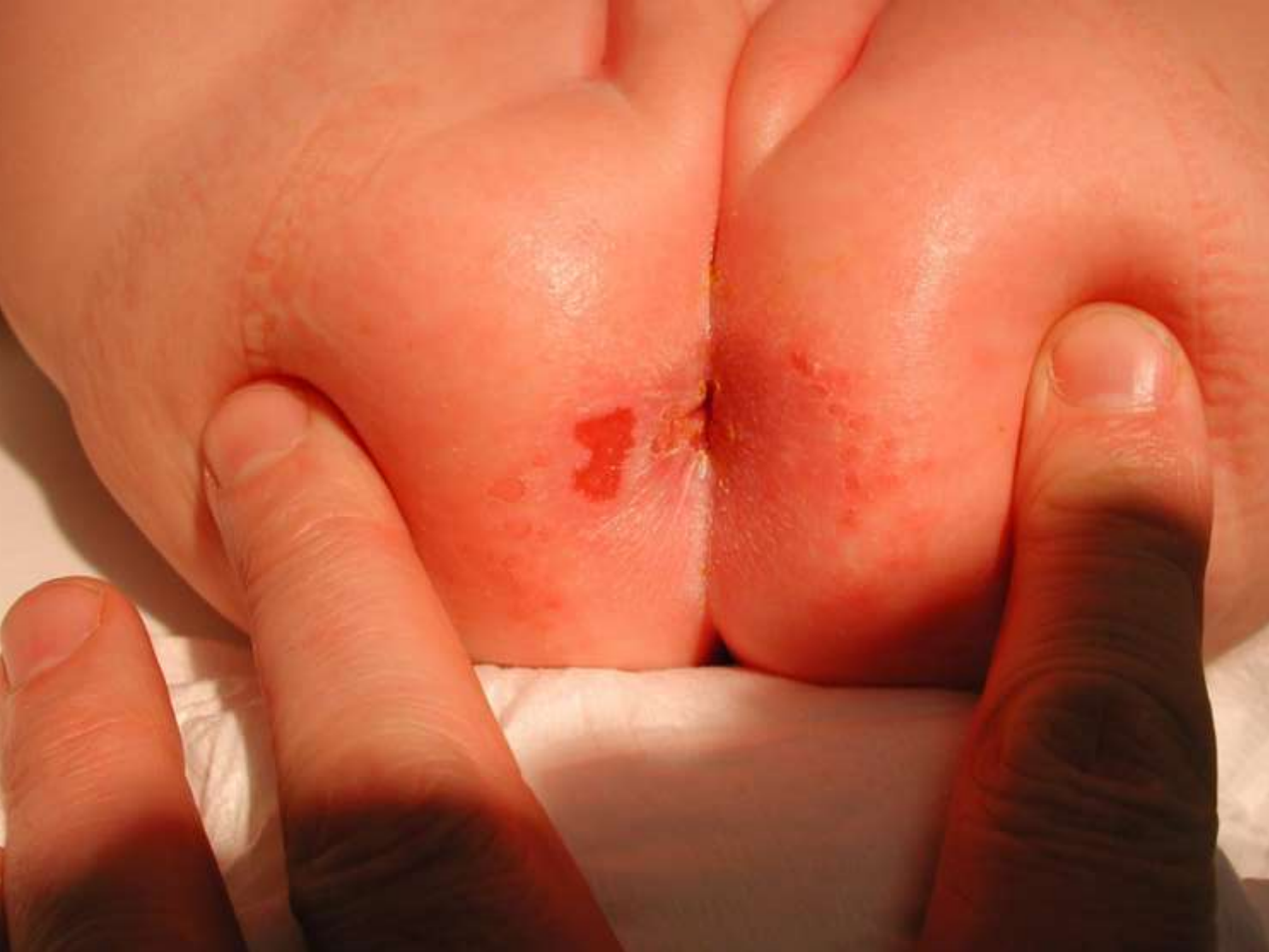


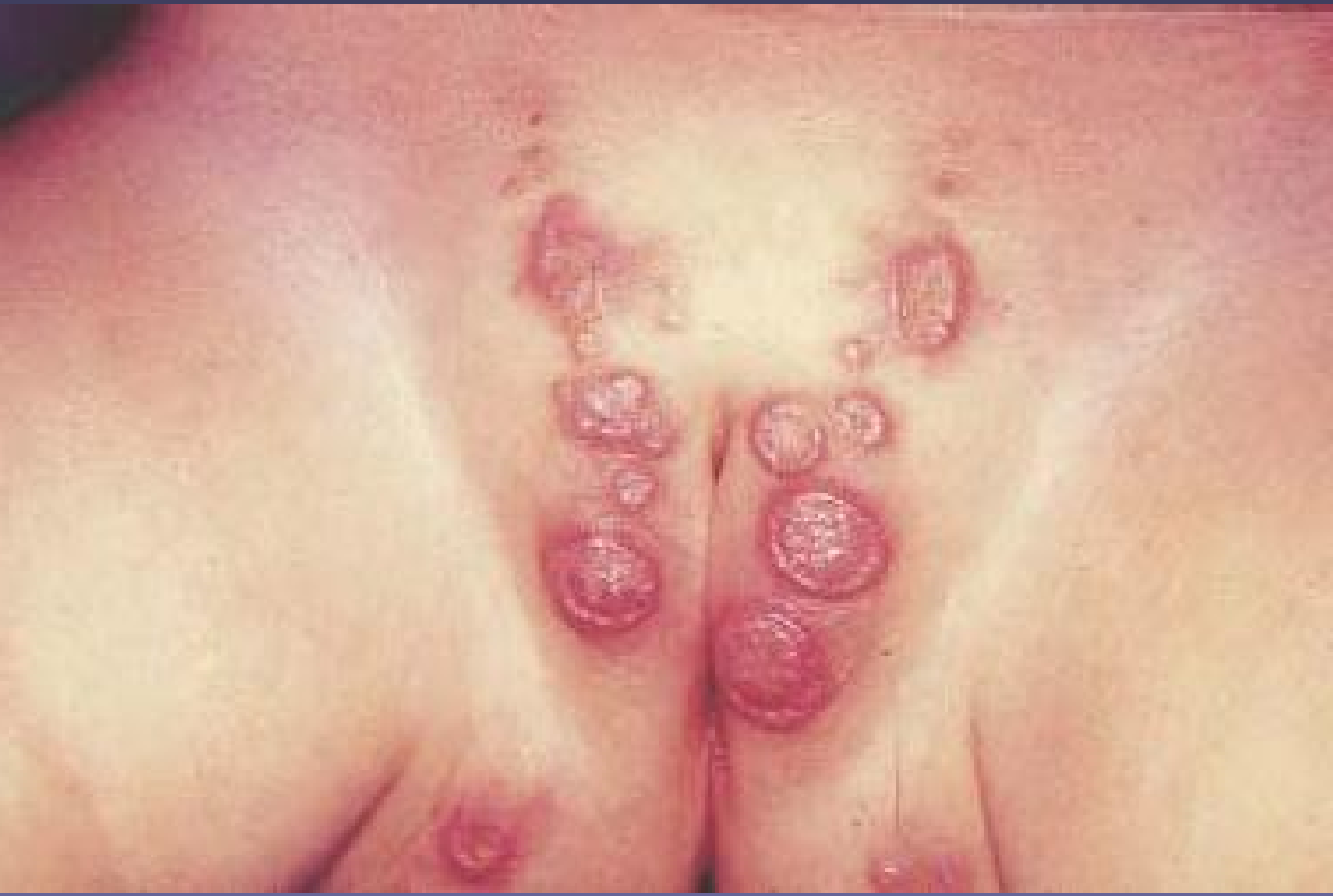




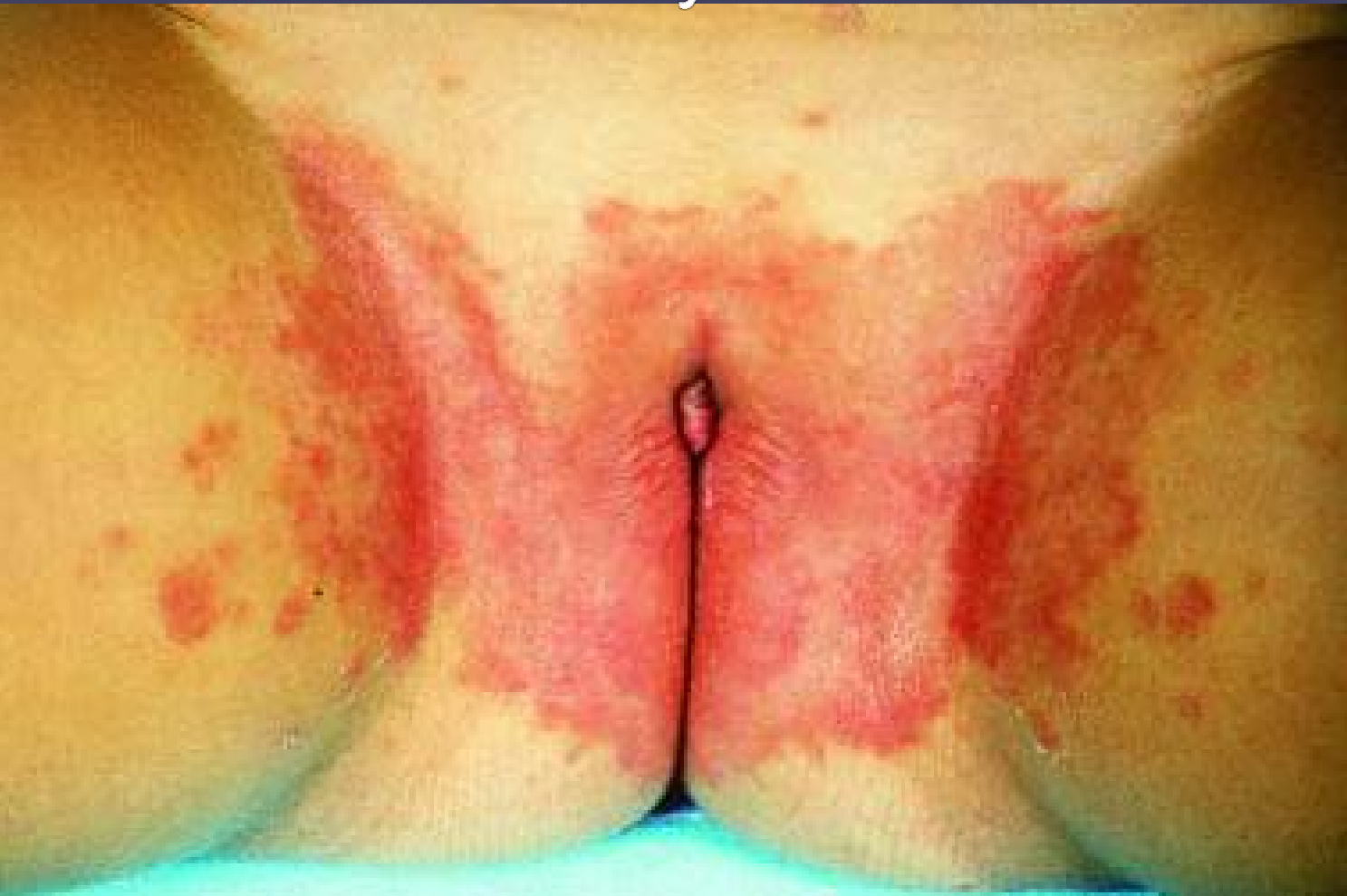


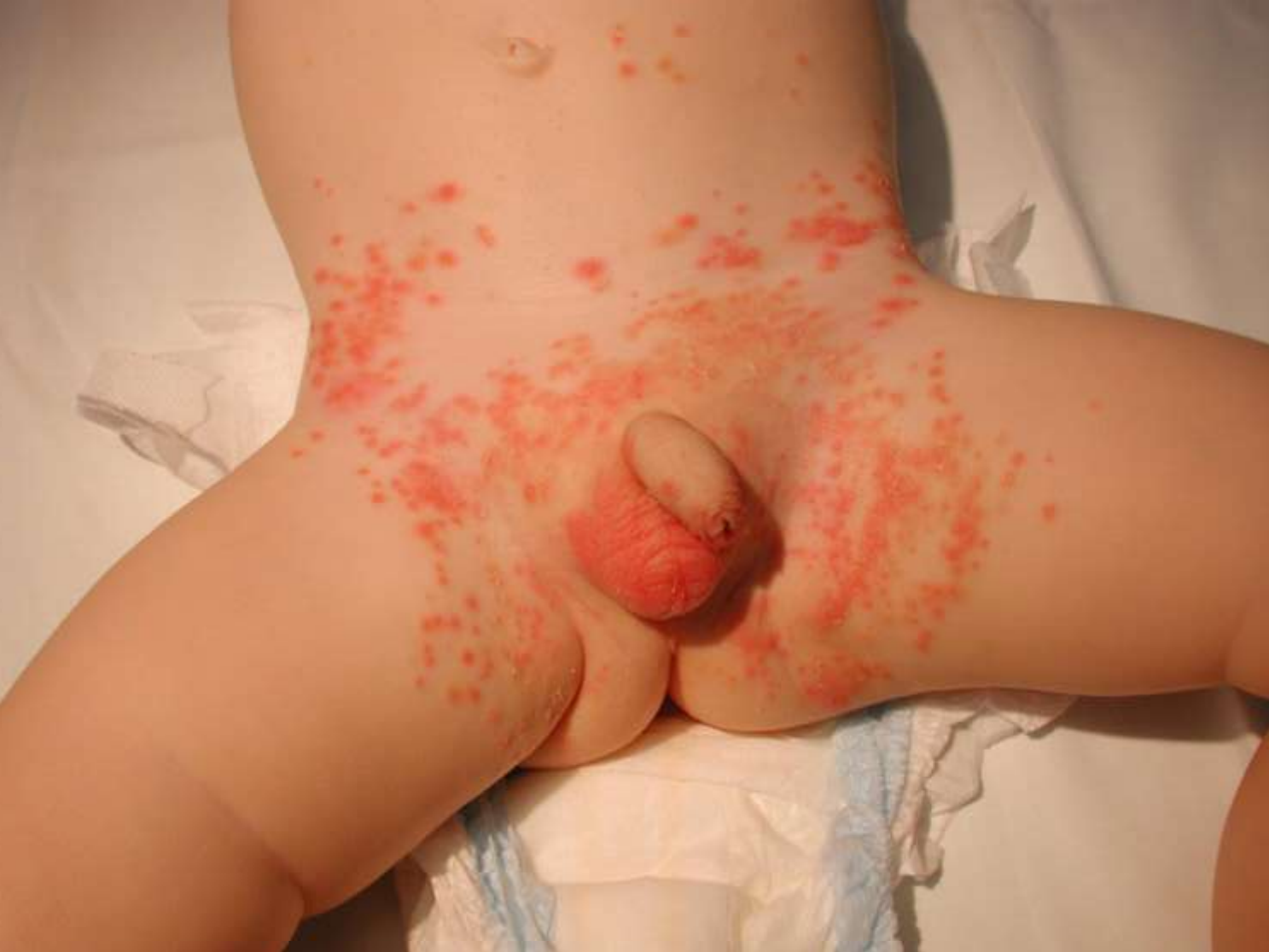






Secondary candida





Aims of management

- Irritation
  - Avoid contributing to irritation
  - Protection from urine and faeces
- Settle inflammation
- Treat any secondary infection

Avoid irritants

- Use disposal nappies
- Frequent changes
- Nappy free time when possible
- Wash with diluted bath oil using cotton balls or Chux towels
  - Dab gently rather than wipe vigorously
- Bath oil and no other irritants in bath
- No antiseptics/cleansers etc

Protection from urine/faeces

- Barrier cream aims
  - Protective barrier against irritants
  - Should still be there at next change
  - Simple, bland formulation
  - No preservatives, fragrances, antiseptics, essential oils

Protection from urine/faeces

- Do not try to remove each change
  - This only adds to irritation
- Individual preference in barrier cream
  - 'Covitol' (Cod liver oil in Zinc)
  - 'Bepanthen' (Dexpanthenol and lanolin)
  - Plain Zinc cream
  - 10% Olive oil in Zinc paste

Settle inflammation

- 1% Hydrocortisone ointment
  - ‘Sigmacort’
  - ‘Egocort’
  - ‘Dermaid’
- Should only require daily application

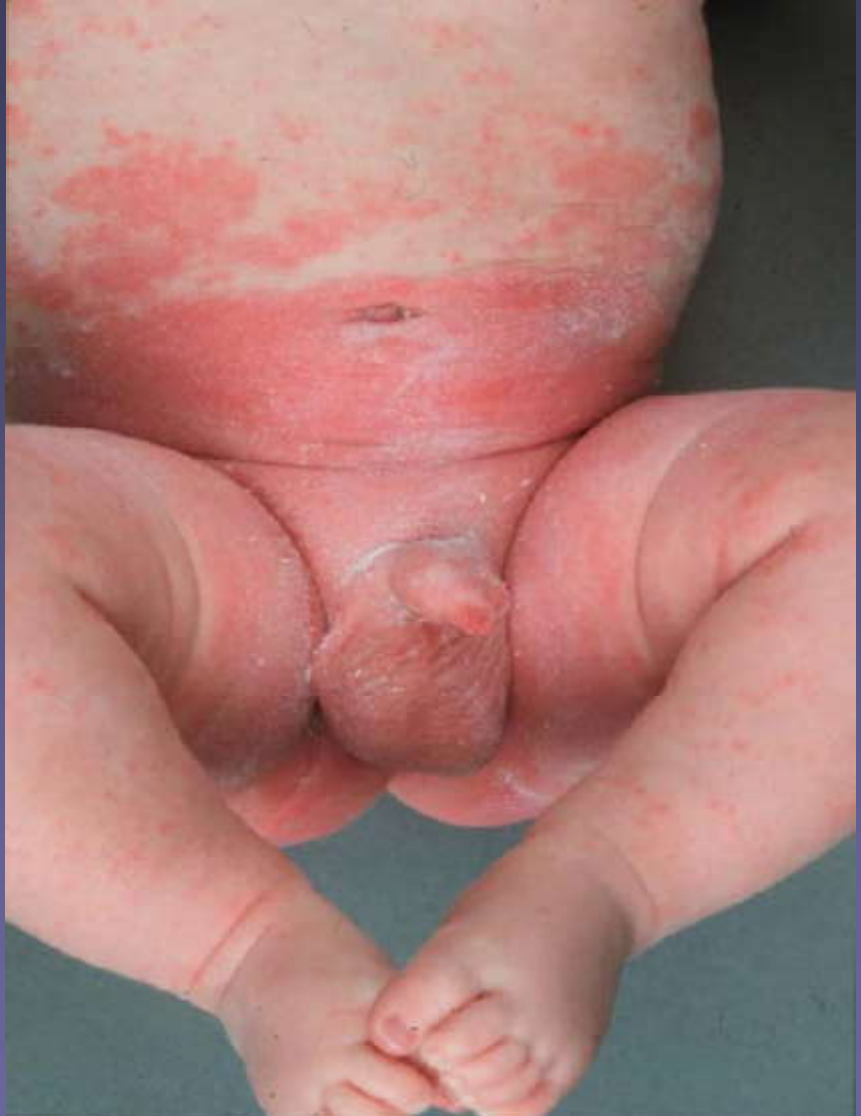
Treat secondary infection

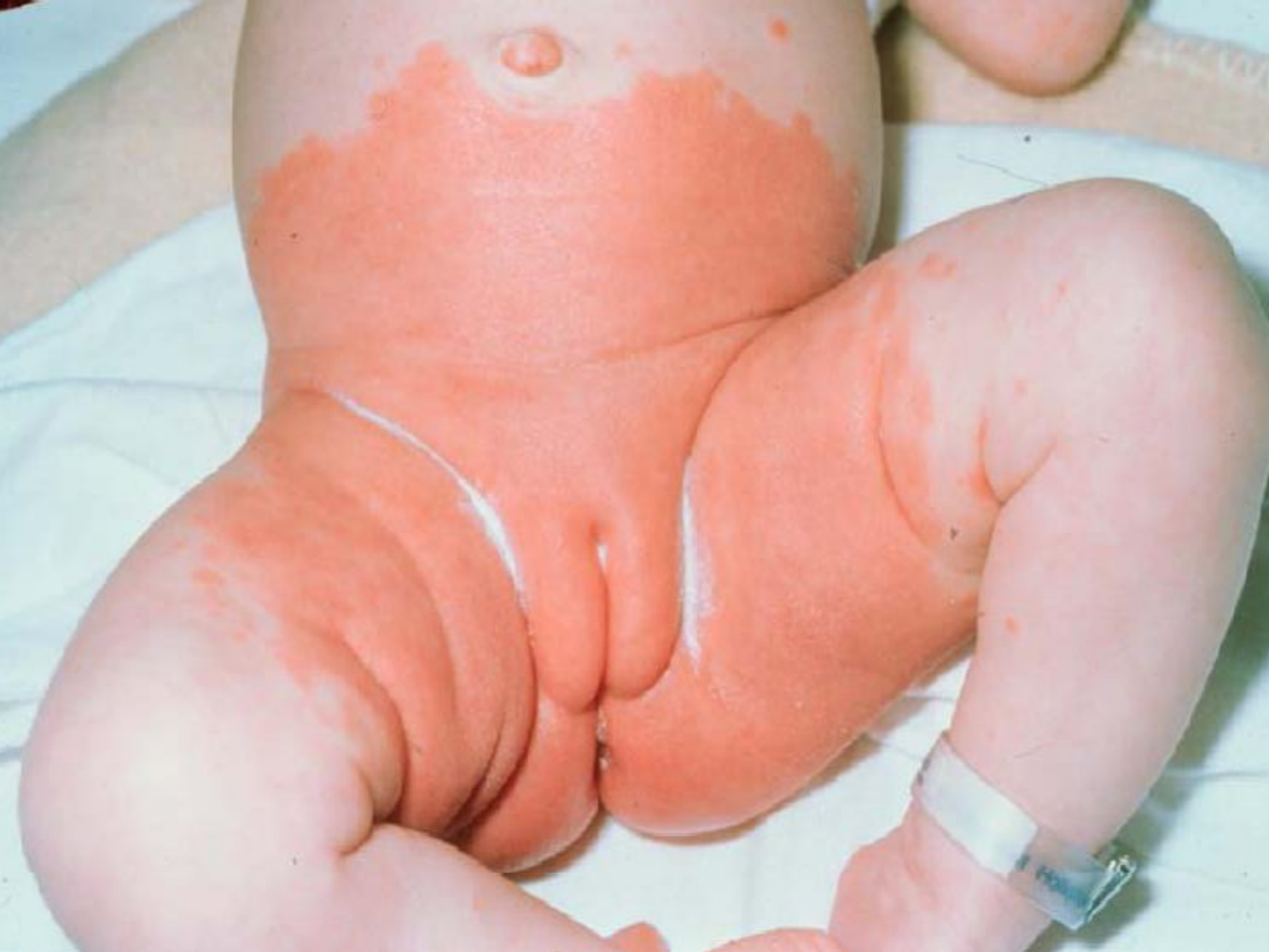
- Add in Canesten/Daktarin with hydrocortisone daily if suspicious
- Mostly unnecessary
- Antifungal creams can be a little irritant
- Have area swabbed if concerned
- Refer to GP for antibiotic therapy only if proven with swab

Treatment summary

- Disposable nappies
- Low irritant wipes
- 1% Hydrocortisone (+/- Canesten) after bath
- Barrier cream every other change

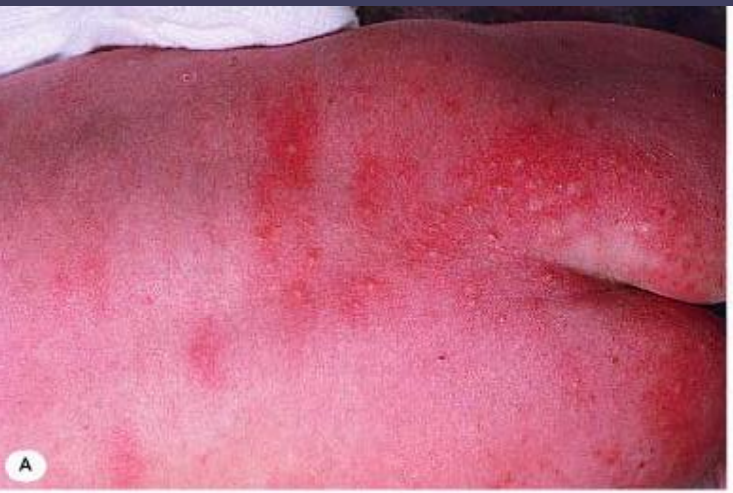
Napkin psoriasis





Erythema toxicum

- Associated with neonatal erythema most prominent on day 2
- Occasional pustules
- well baby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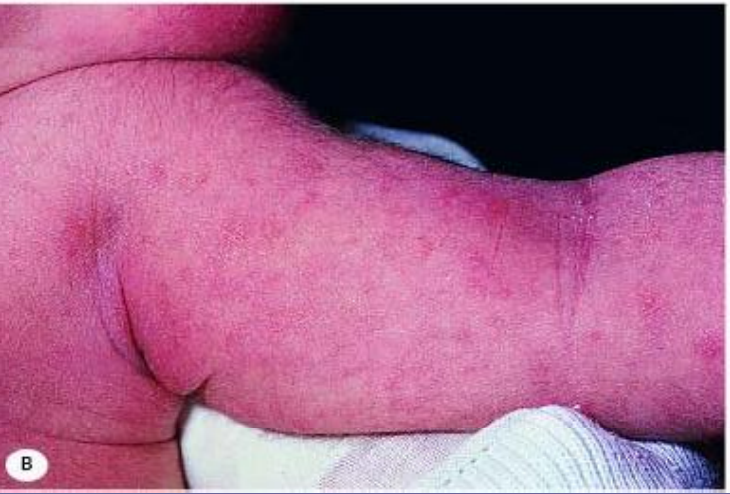
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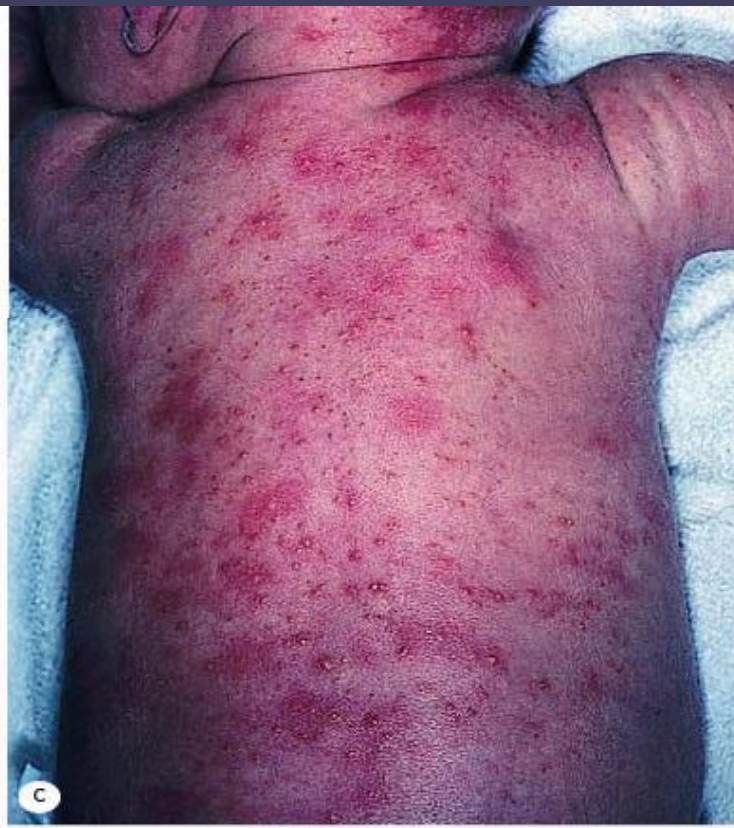
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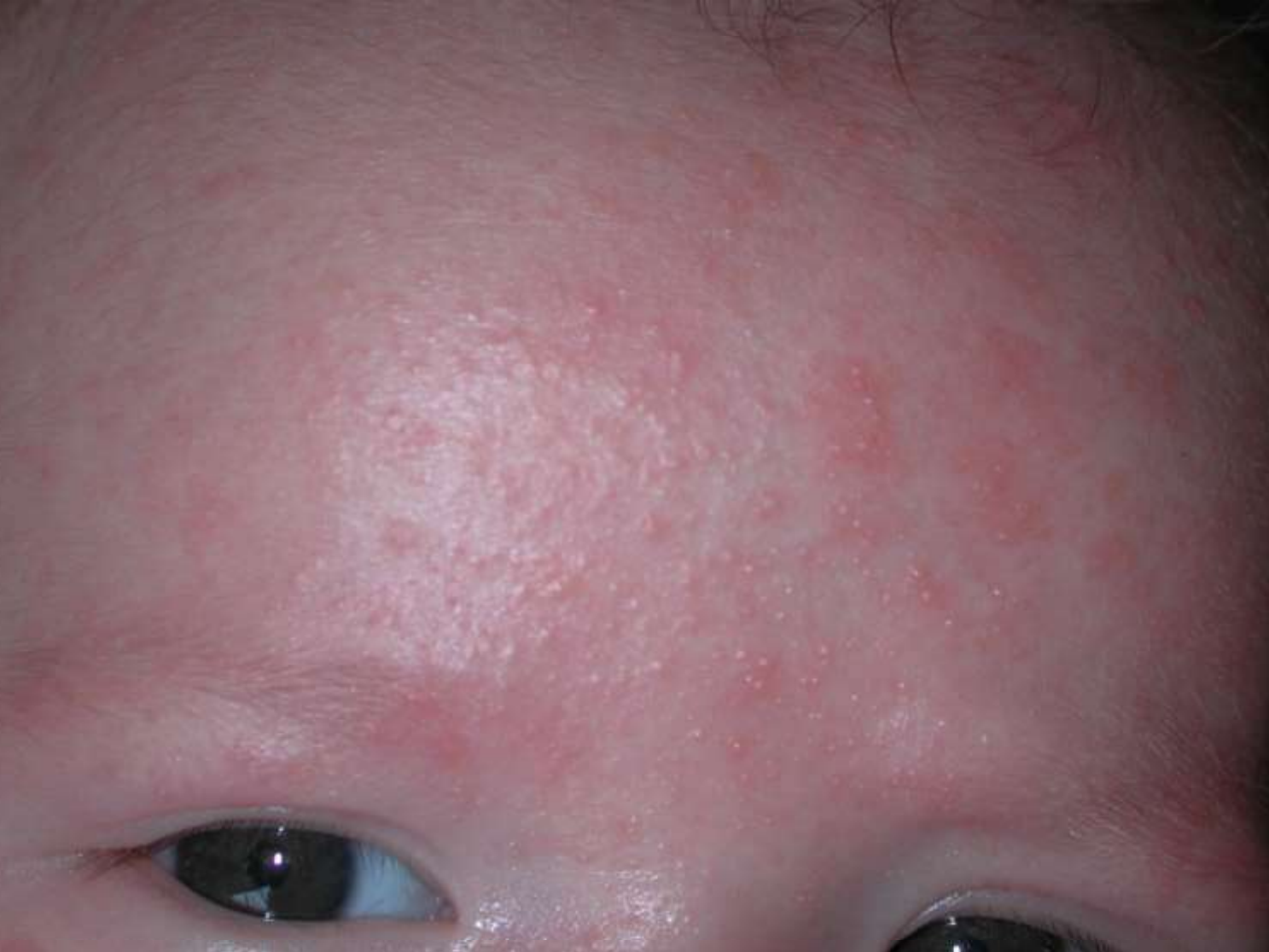
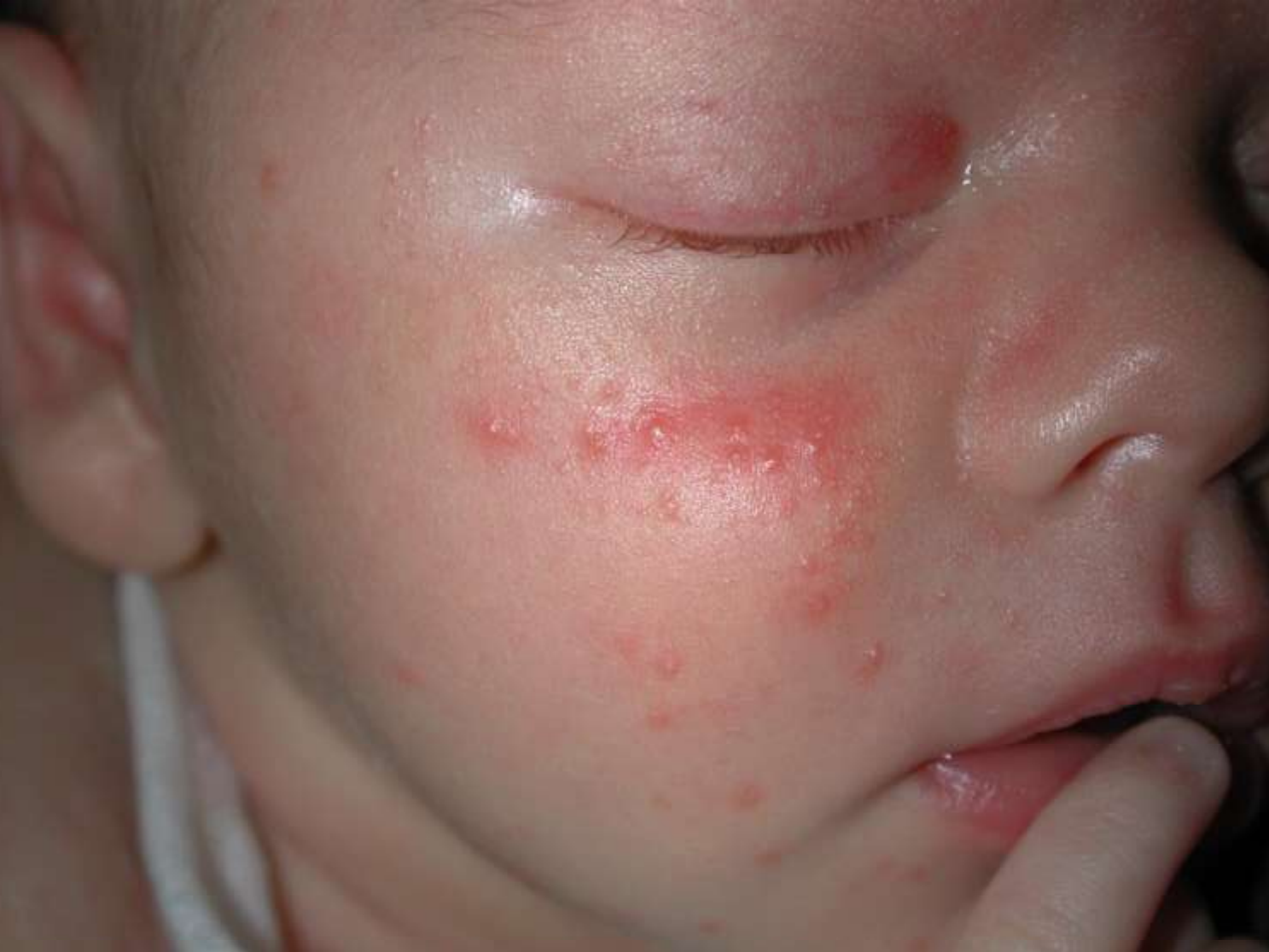
‘6 week’ eruption

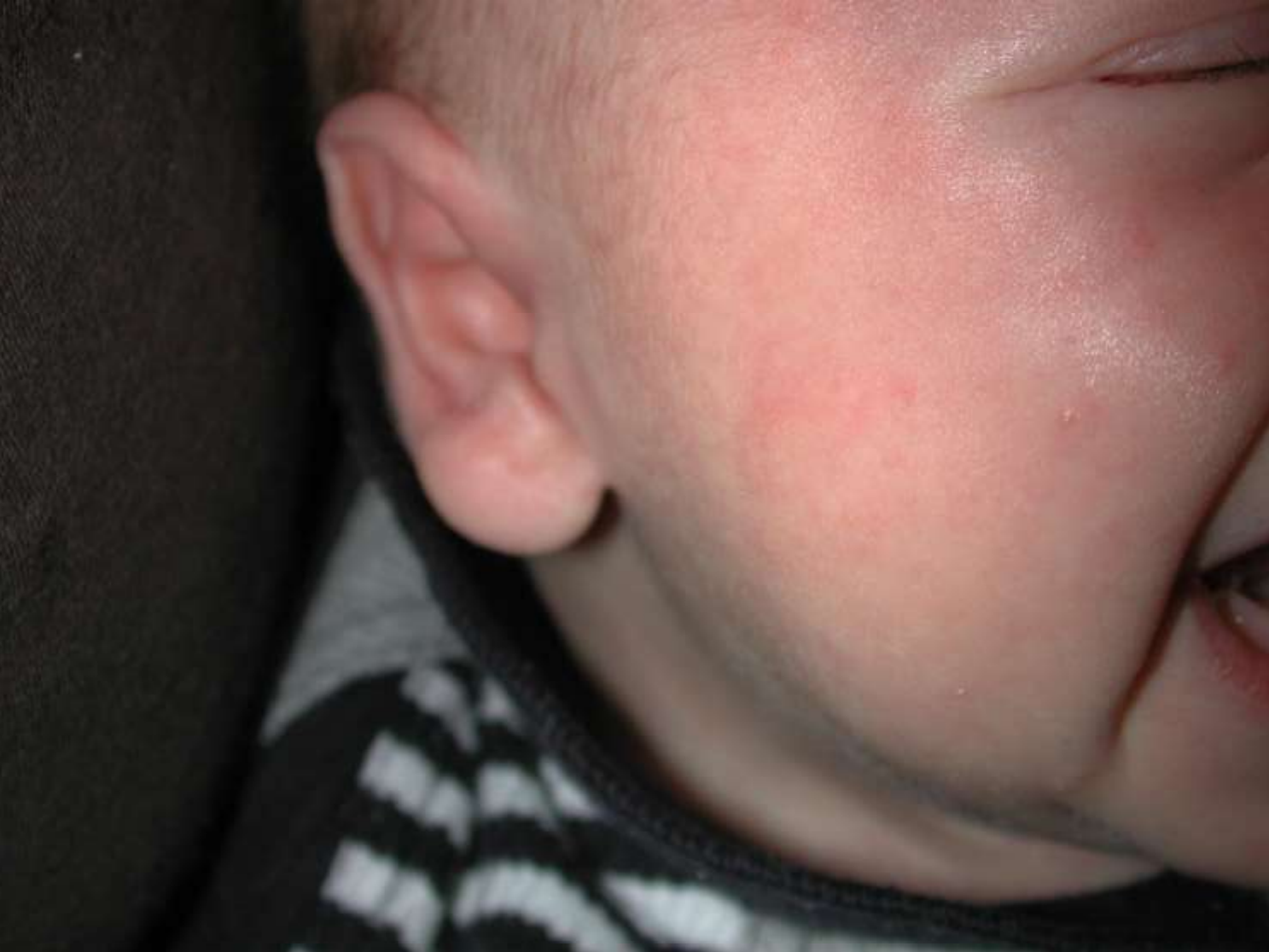
- Otherwise known as ‘milk spots’, infantile acne
- Is really a yeast folliculitis
- Fades as sebaceous glands settle to quiescent childhood levels



Yeast folliculitis- treatment

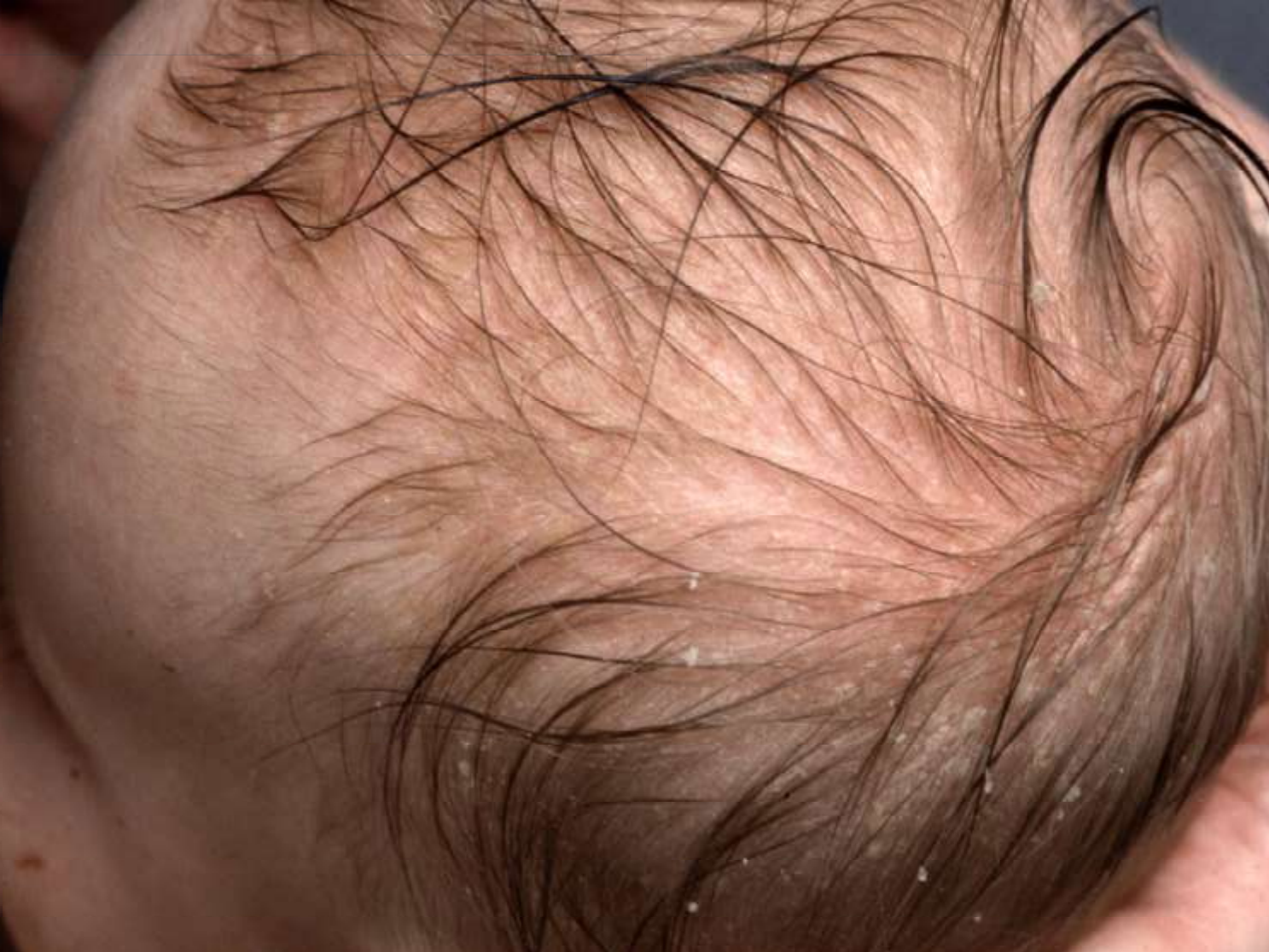
- Application of either 2% Ketoconozole cream or Ketoconozole shampoo diluted 1 in 10, applied via cotton bud.
- Twice per day applications usually clears the eruption in a few days.





Cradle cap

- Probably analogous to dandruff in the adolescent/adult
- ‘greasy’ scale
- generally not pruritic
- Inflamed cradle cap regarded as ‘seborrhoeic dermatitis’

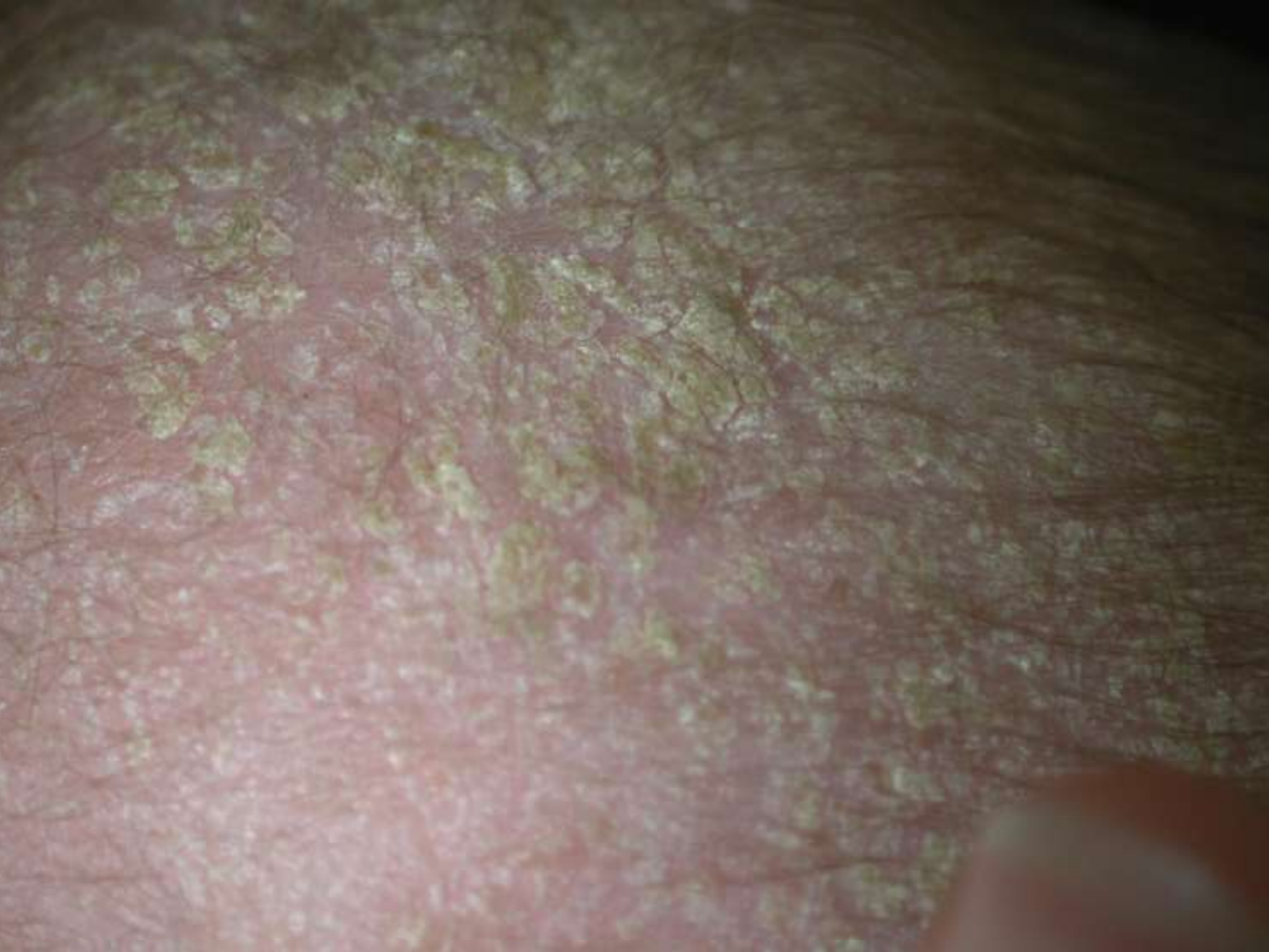


Cradle cap- treatment

- Not necessary
- Remove scale without irritating scalp
  - soap substitutes, olive oil, bath oil
  - may use comb gently if stuck in hair
- Ketoconozole shampoo if recurrent
  - Nizoral, Sebizole
- Salicylic acid creams only rarely required

Scalp eczema

- Do not diagnose cradle cap after 6 months
- Scale is harsher
- Itch common
- Usually eczema elsewhere



Scalp eczema

- Treat as eczema elsewhere
- Use topical steroid ointments rather than lotions
- Shampoos will irritate- use soap substitutes
  - no role for anti-yeast therapy
- Salicylic acid will worsen

Scalp scaling

- Neonates have seborrhoeic skin
  - hence may have cradle cap or seborrhoeic dermatitis
- Children have inactive sebaceous glands
  - hence may develop eczema or tinea
- Psoriasis may occur at any age

RASHES WITH PRESUMED VIRAL AETIOLOGY

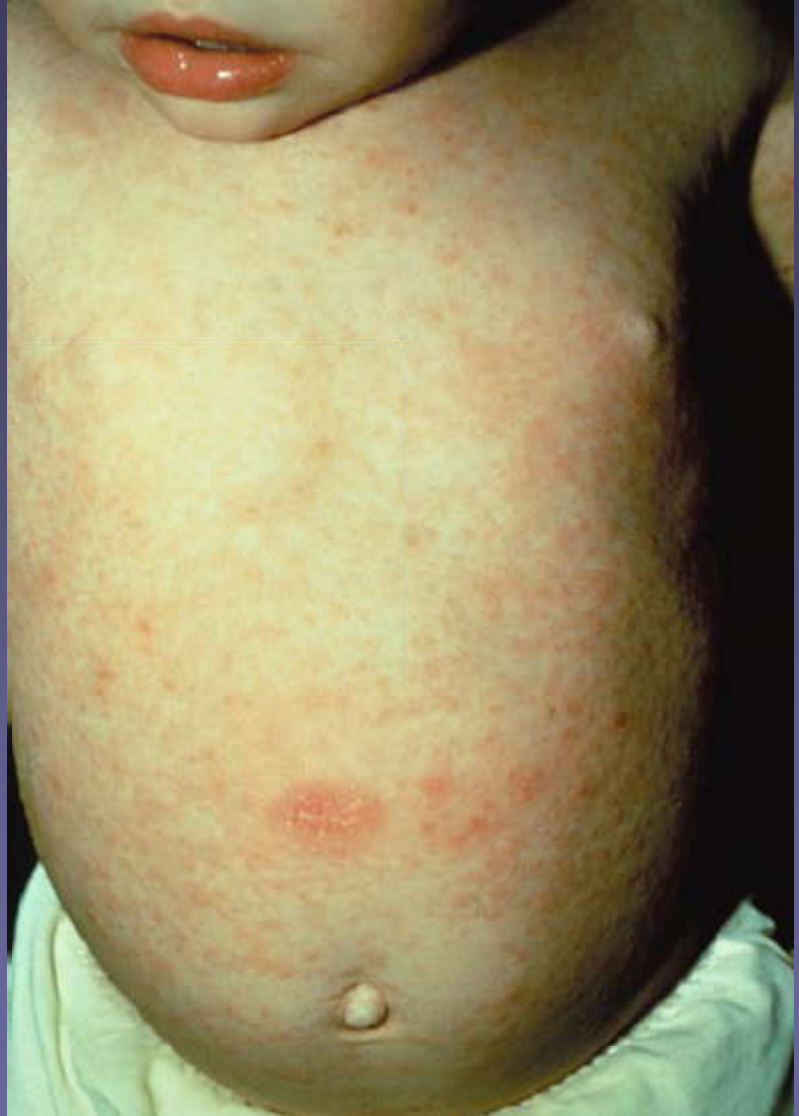
- Pityriasis rosea
- Unilateral laterothoracic exanthem
- Papular acrolocated syndrome (Gianotti-Crosti syndrome)

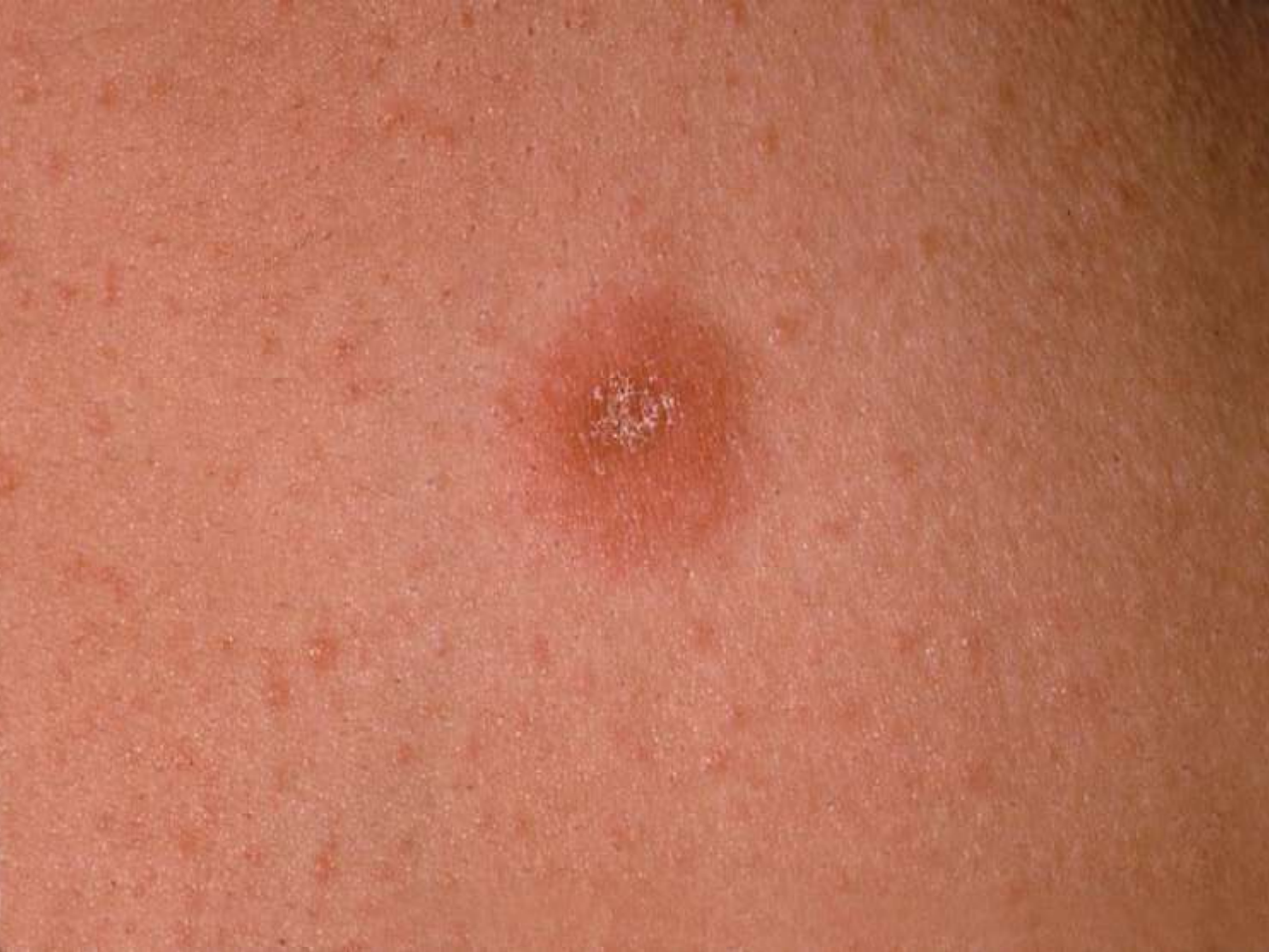
Pityriasis Rosea

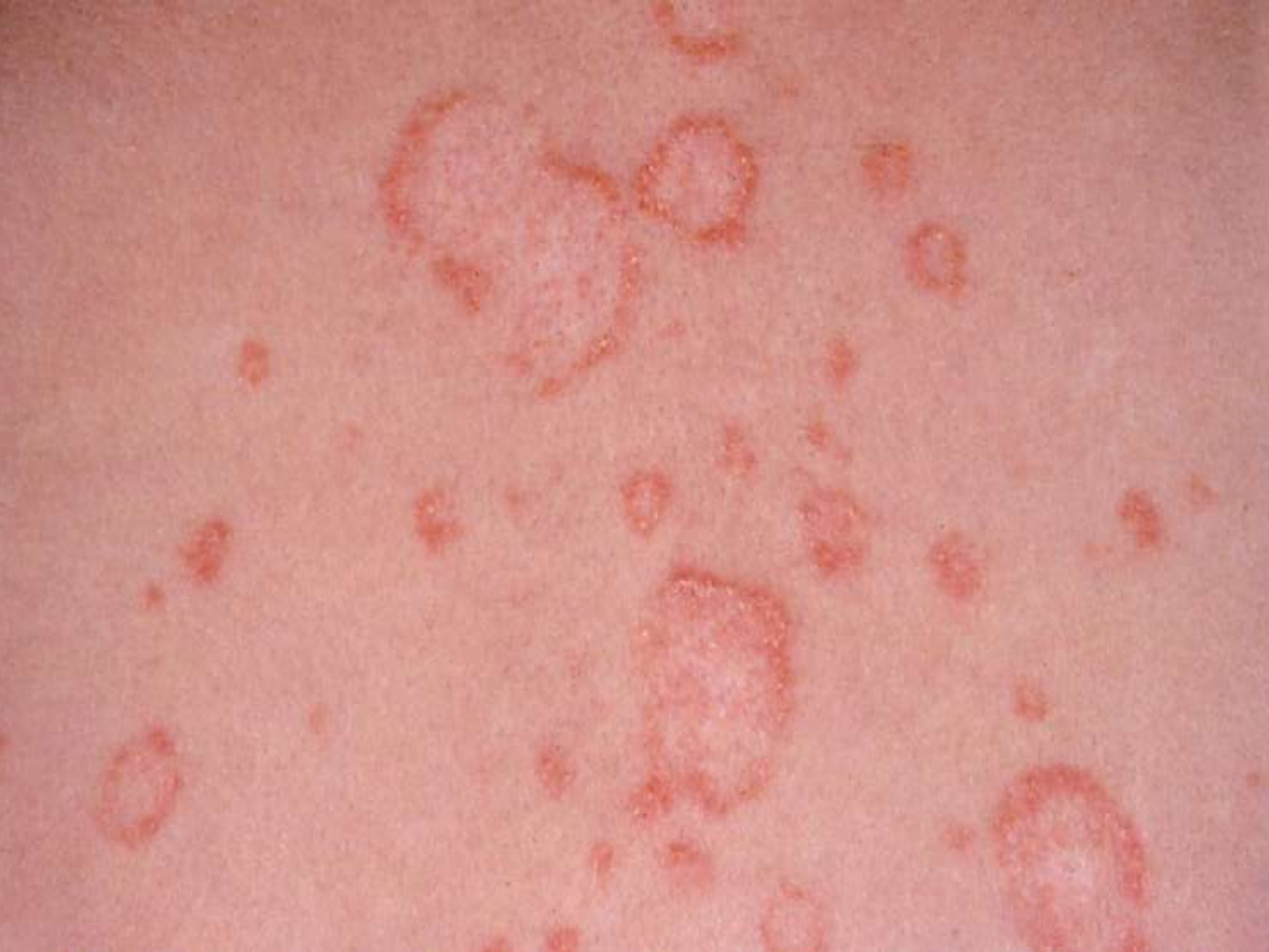
- Absent or minimal prodrome
- 'Herald patch' in 80%
  - usually near proximal joint
  - larger than other patches

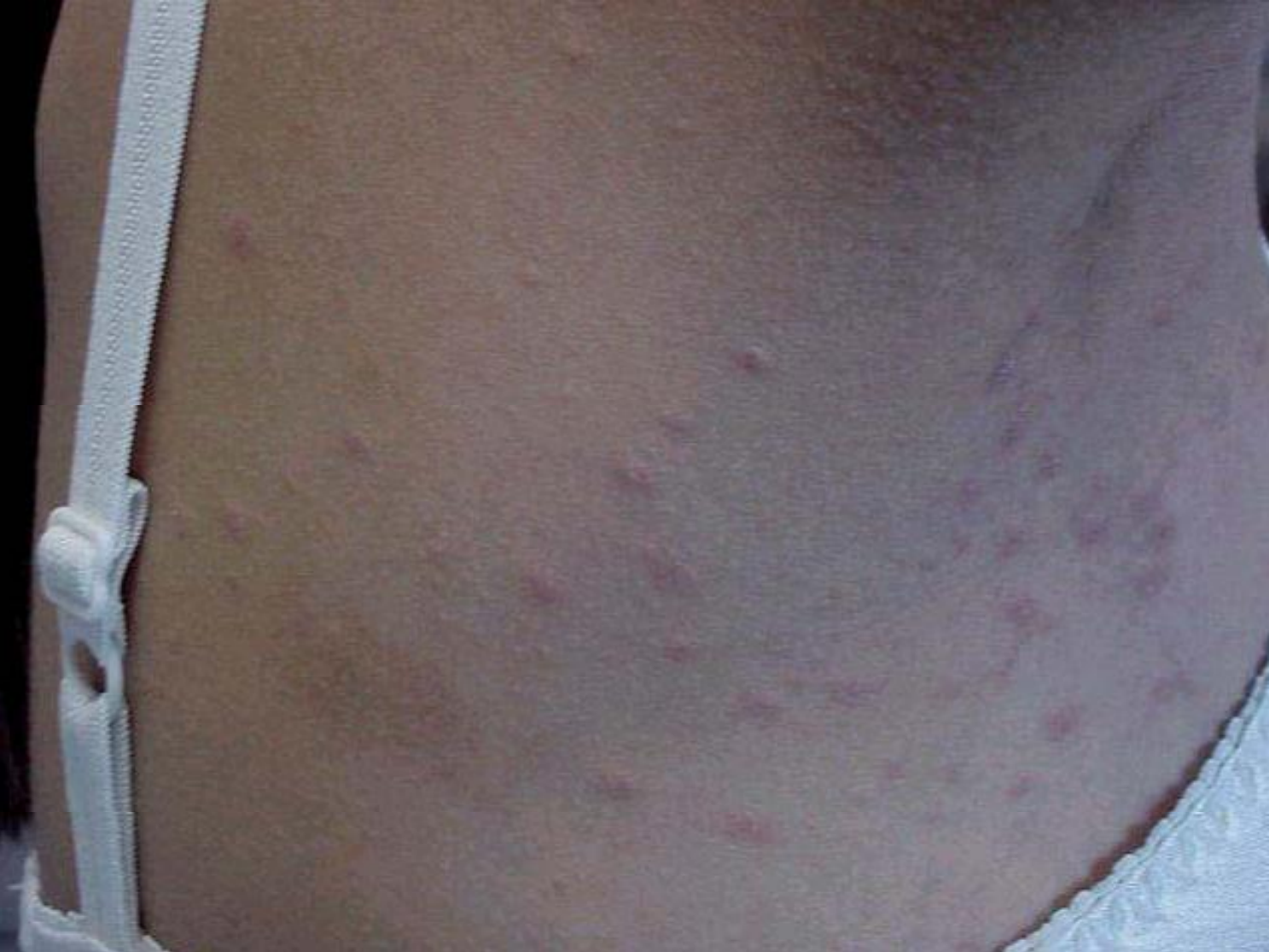
Pityriasis Rosea

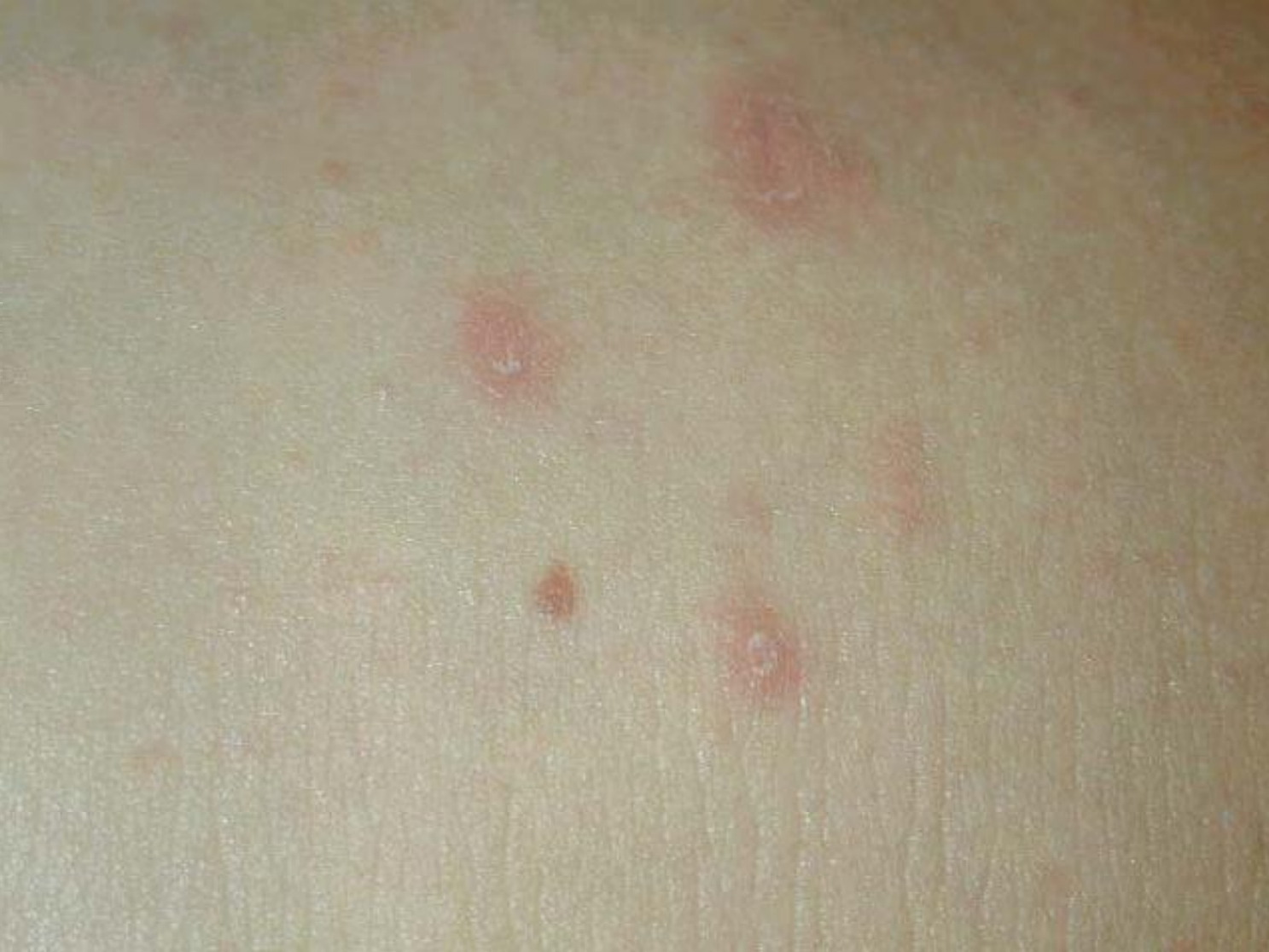
- Eruption occurs hours to days later
  - symmetrical and proximal
  - long axis of patch in Christmas tree distribution
  - free edge of scale internally
- Usually lasts 3-6/52
  - topical steroids and/or UVB for symptoms











Pityriasis Rosea

- Differential diagnosis:
  - drug eruption
  - secondary syphilis
  - guttate psoriasis
  - discoid eczema
  - pityriasis lichenoides

Pityriasis Rosea

Treatment

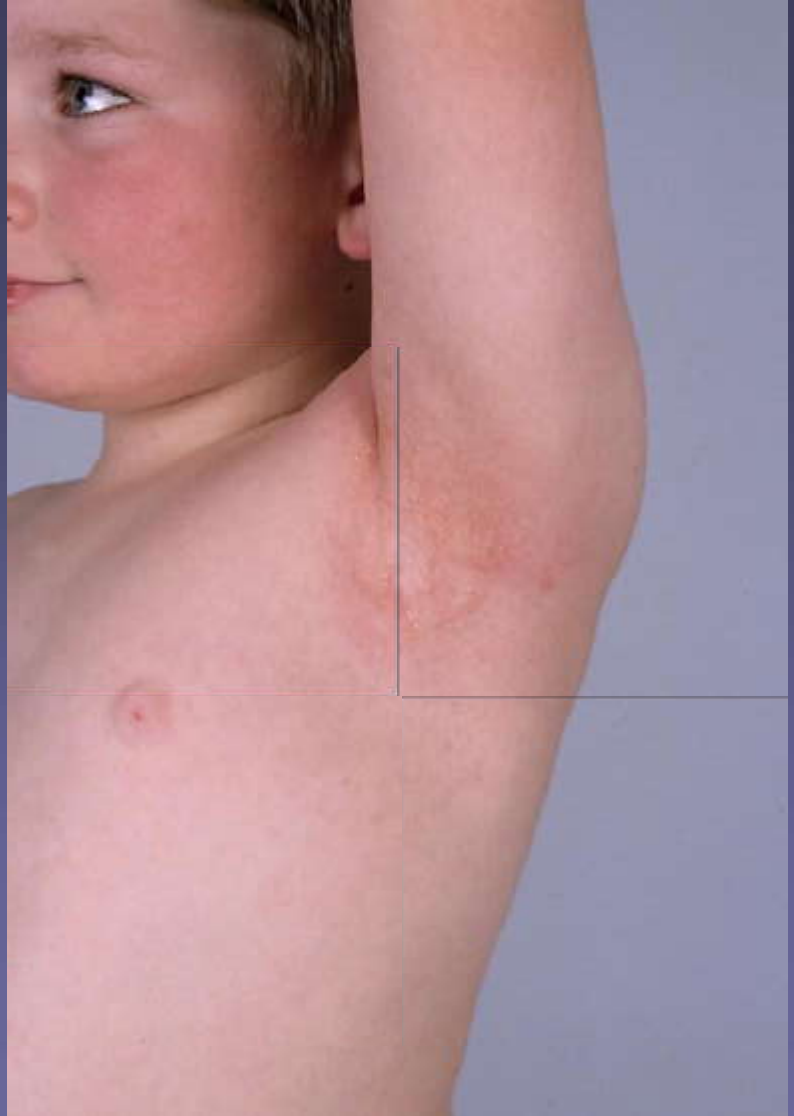
- None required
- Topical steroids not very helpful
- Sunlight/UVB very useful
- ?Erythromycin

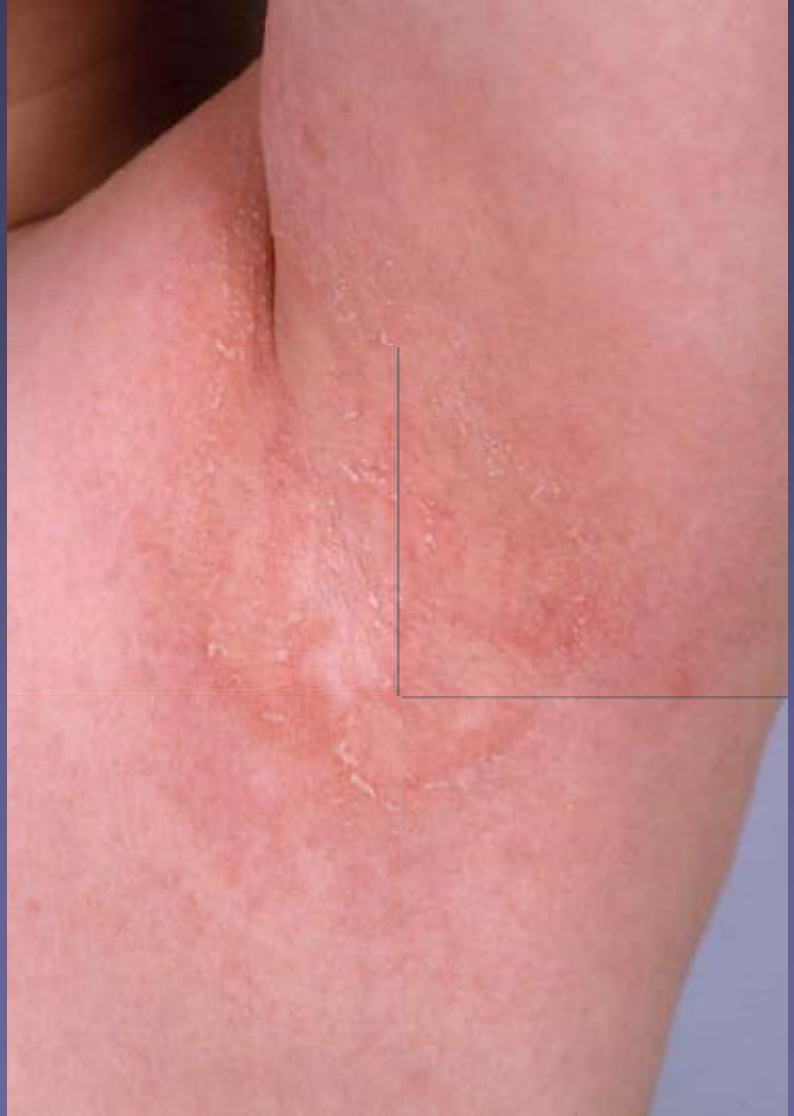
Unilateral laterothoracic exanthem

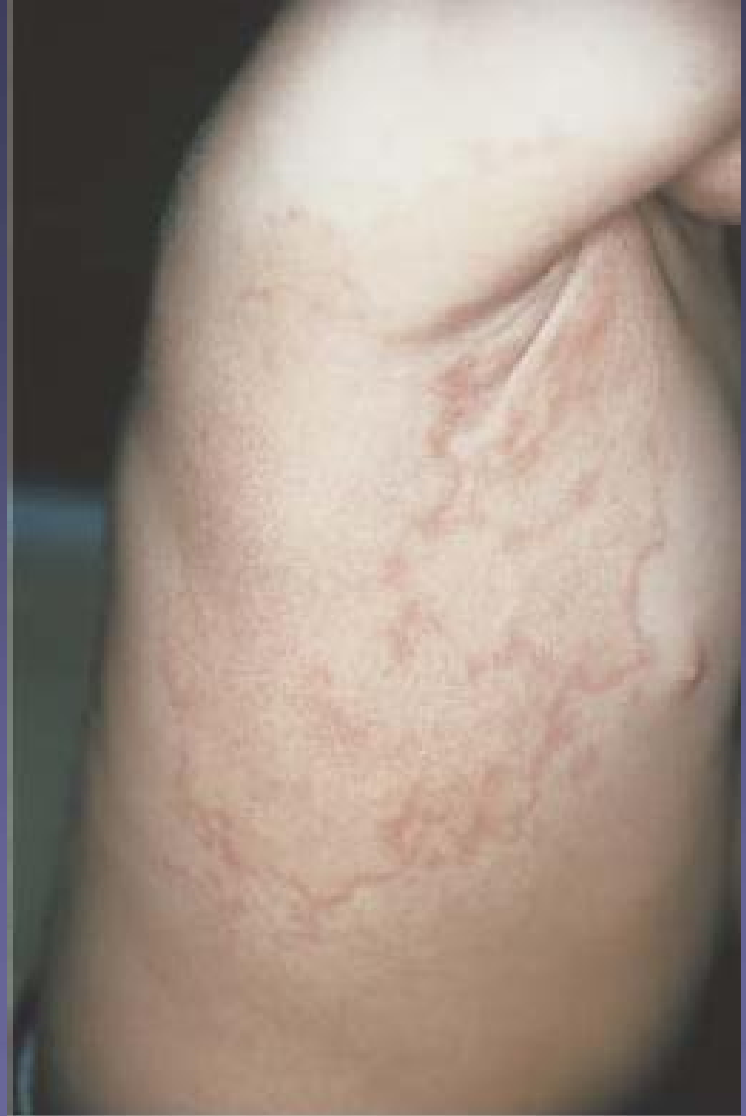
- Recently described entity
- Some have preceding illness
- 0-5 years
- Commoner in spring and in girls
- Histology- eccrine gland infiltration with lymphocytes

Unilateral laterothoracic exanthem

- Discrete erythematous papules eventually coalescing
  - sometimes with a secondary eczematous component
- Commence unilaterally in axilla before spreading ipsilaterally over trunk then bilaterally
- Child remains well
- Mean duration 5 weeks





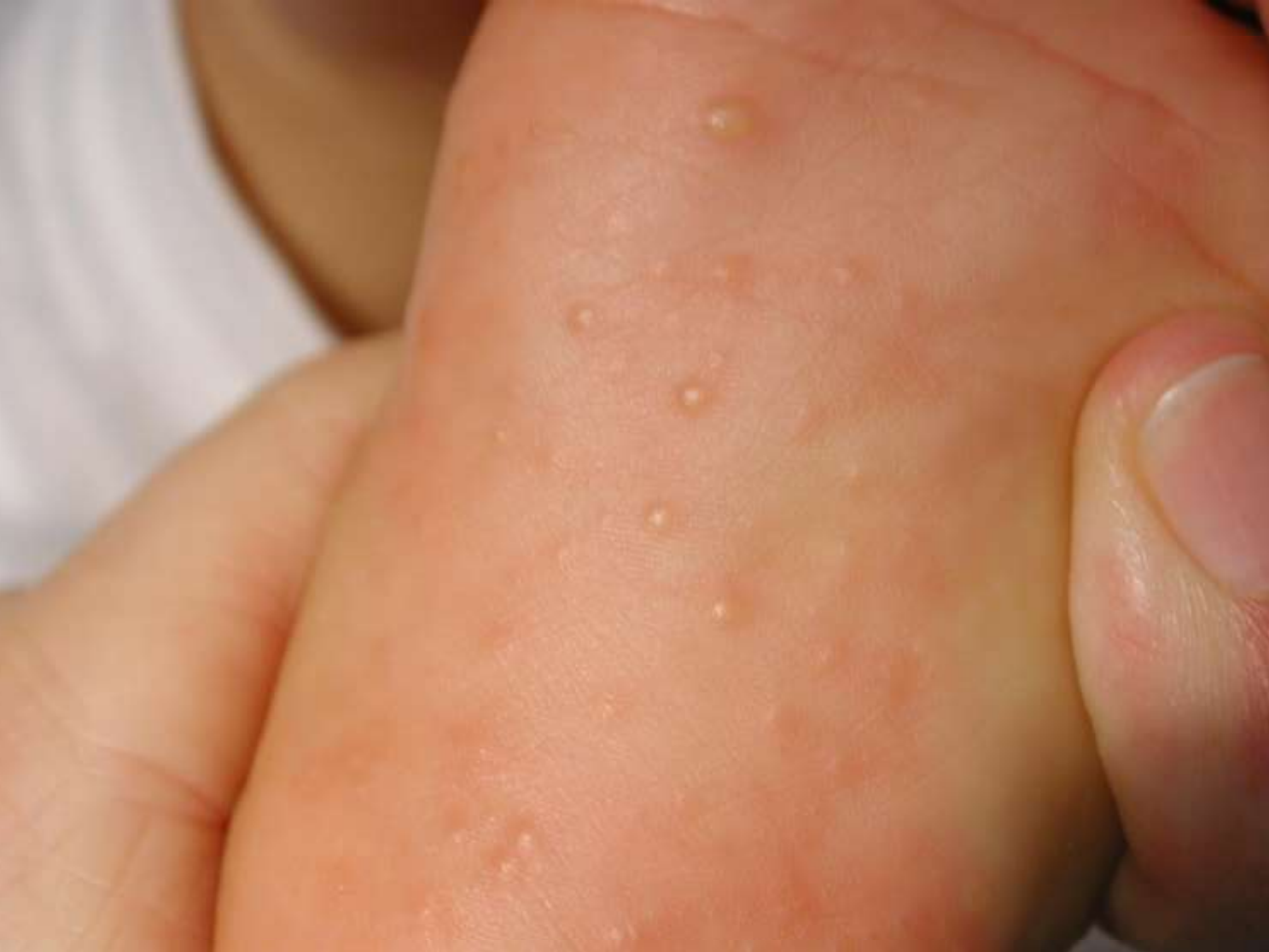


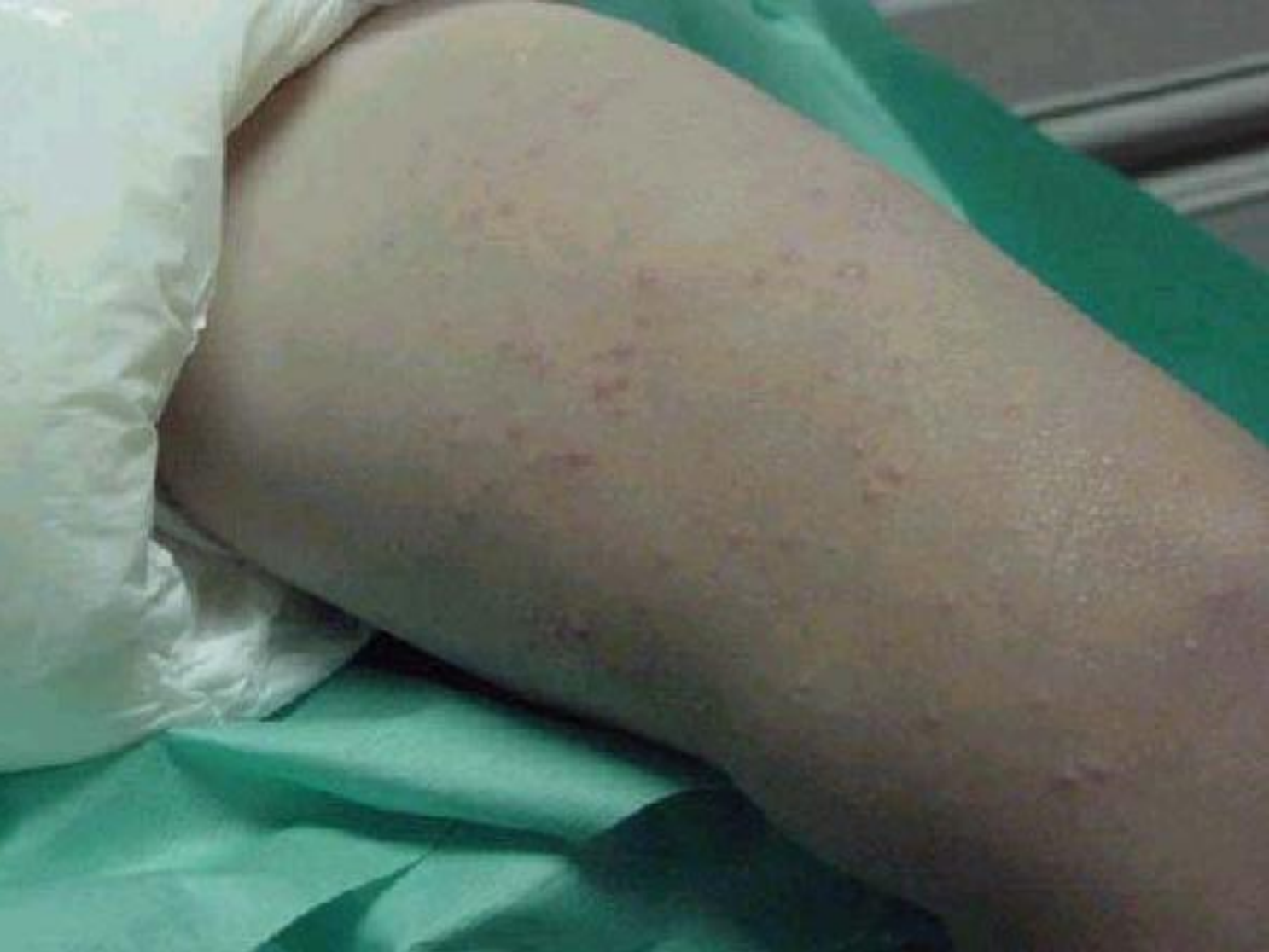
Papular Acrolocated Syndrome

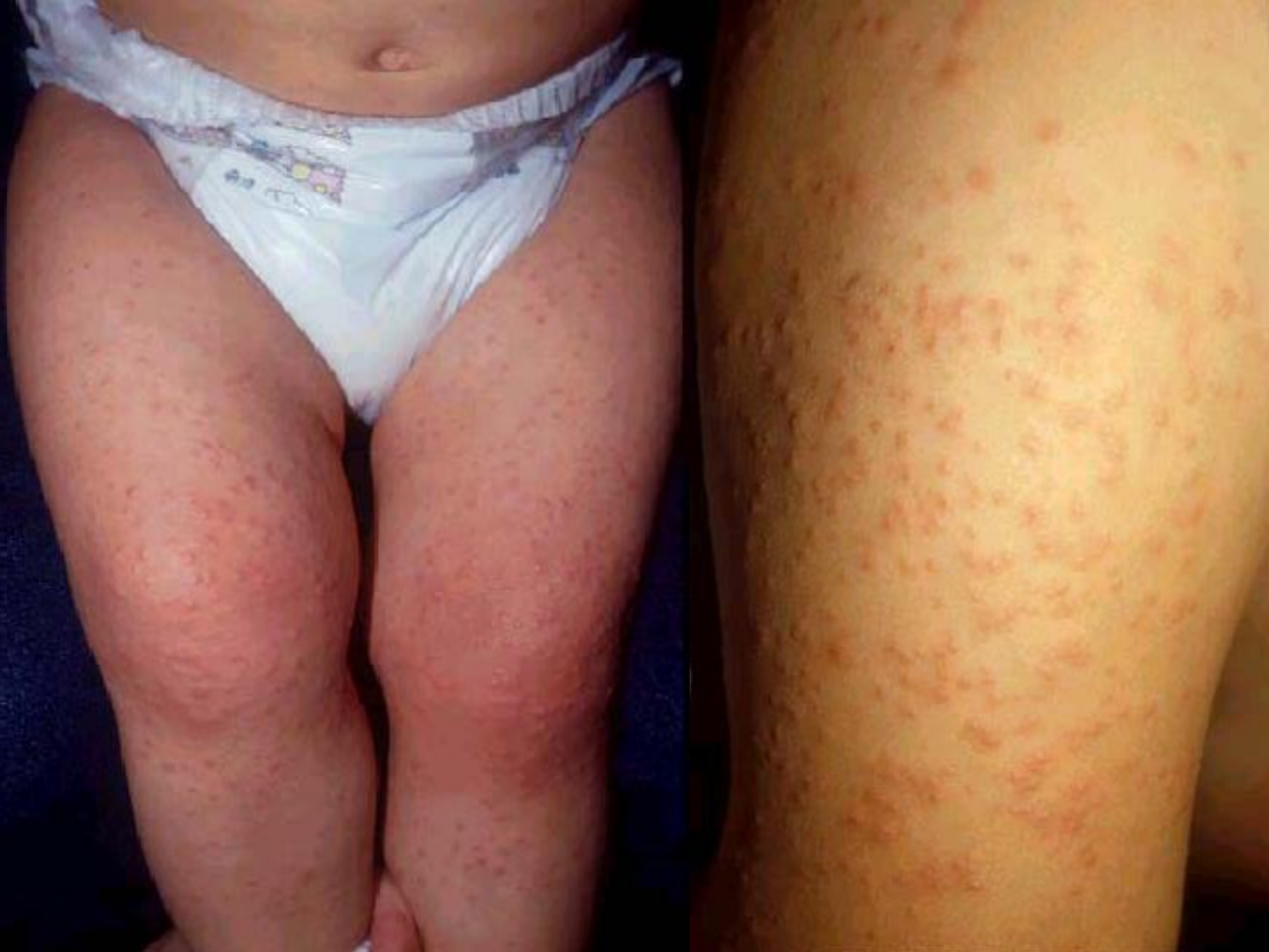
- 'Giannotti-Crosti syndrome'
- Described initially as post-Hepatitis B syndrome but now shown to be a non-specific response to viral infection
  - Hep B cases usually anicteric
  - vast majority in Australia due to enteroviruses
- Age 6/12 to 12 years usually

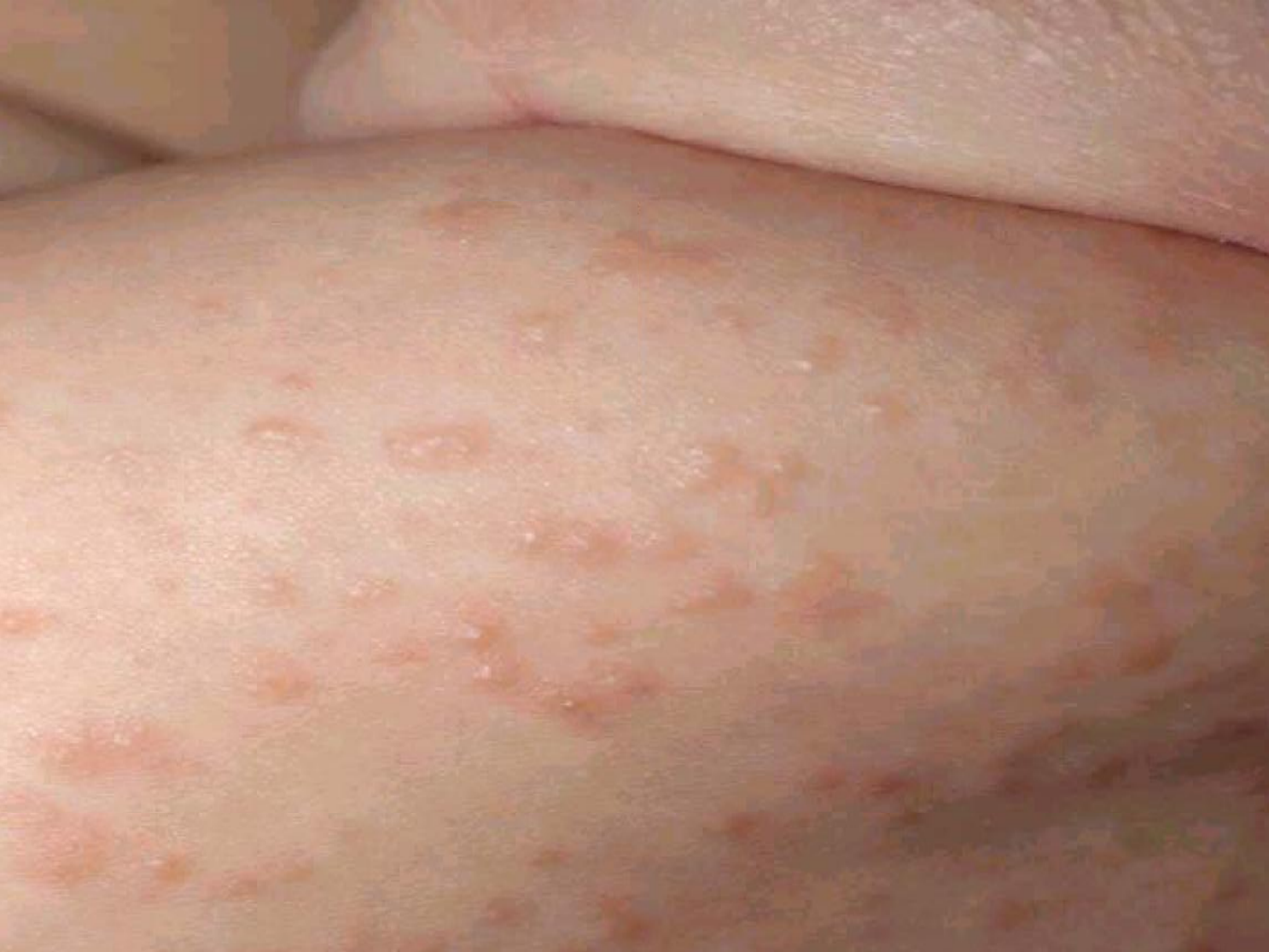
Papular Acrolocated Syndrome

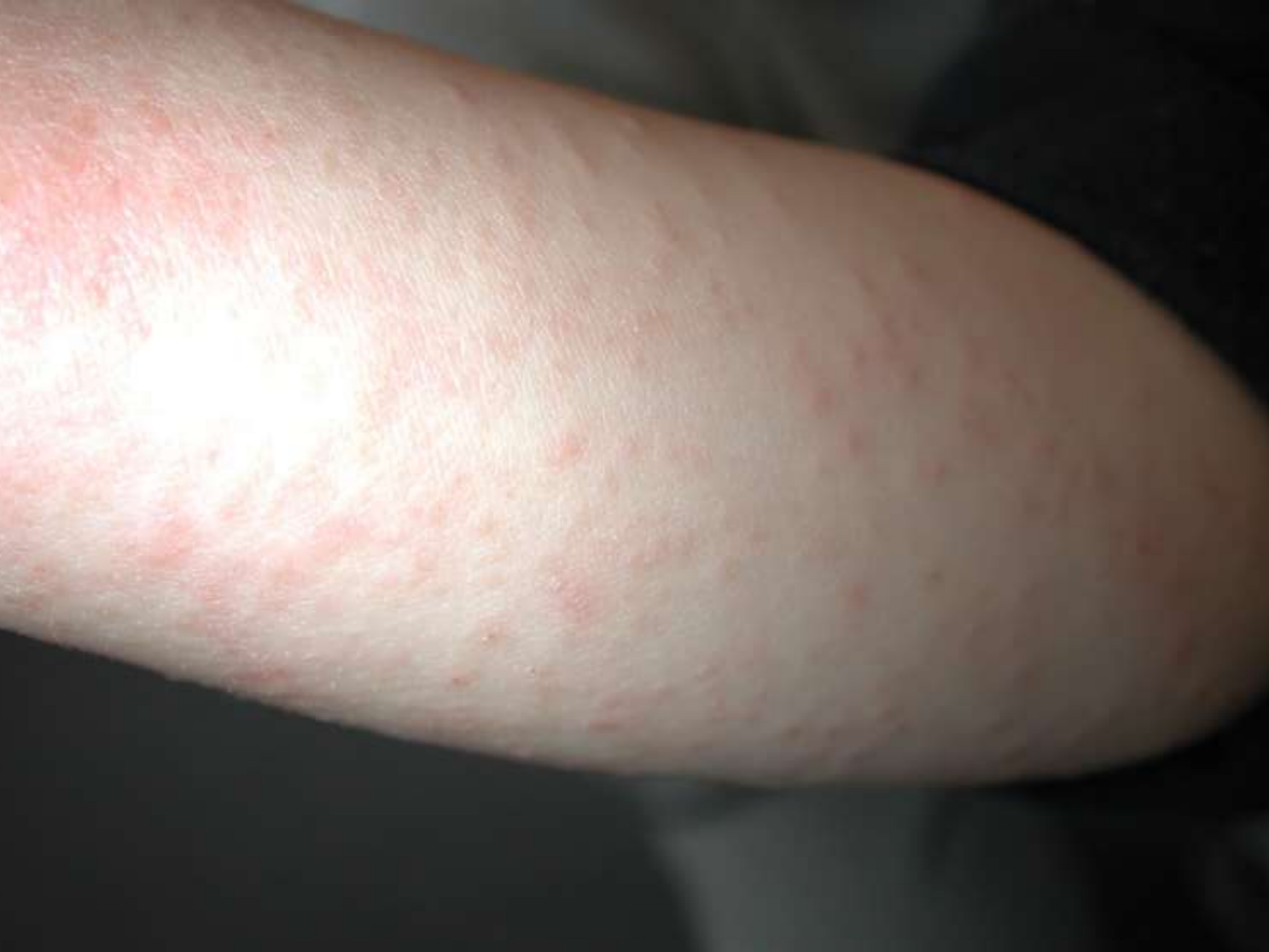
- Urticaria-like papules develop on limbs, buttocks and face
  - little to no pruritus
  - papules remain small and fixed
  - monomorphic for given patient
- Fades after 2-8/52 with mild desquamation
- No treatment required- ?role of serology for Hep B

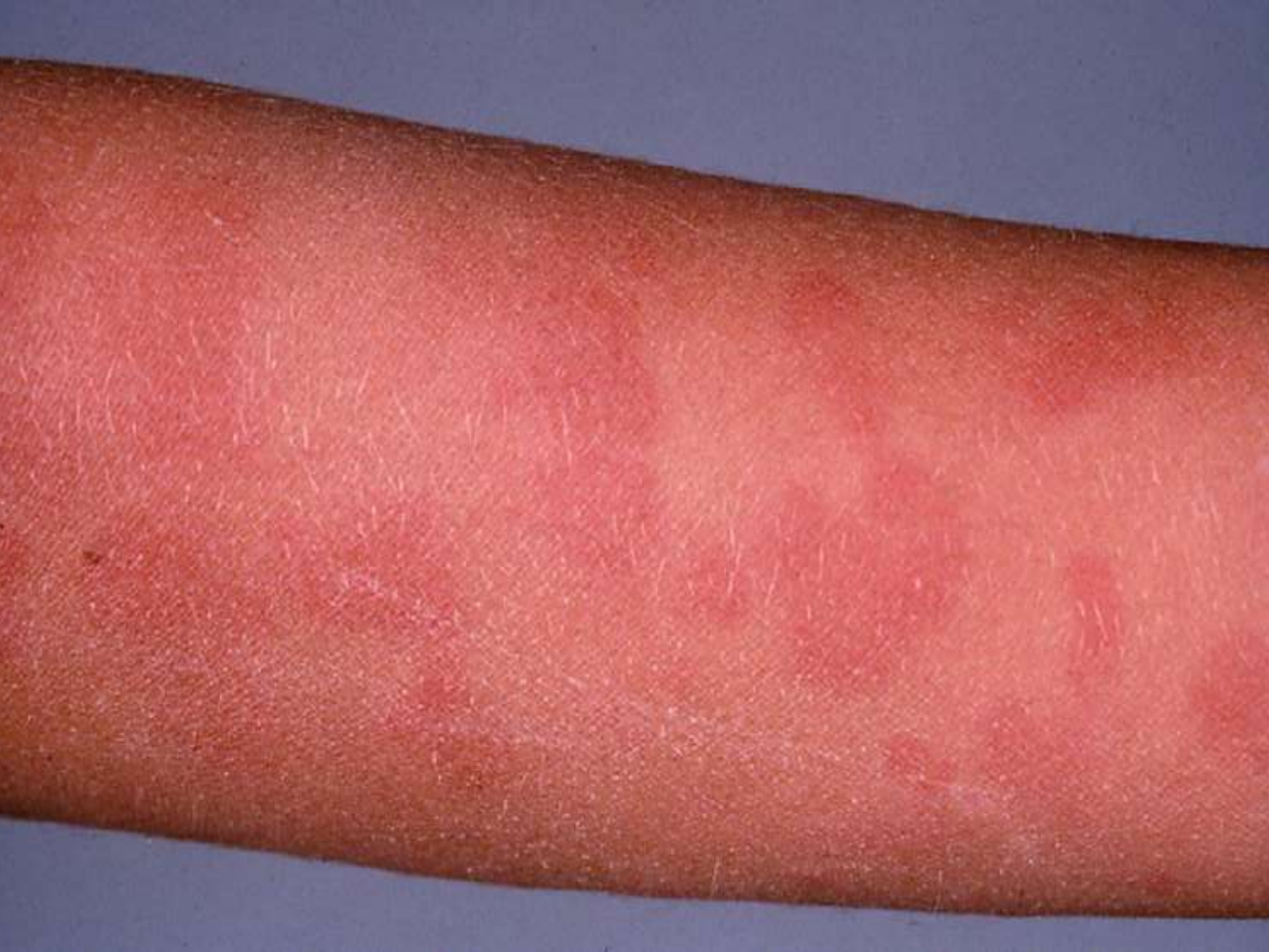


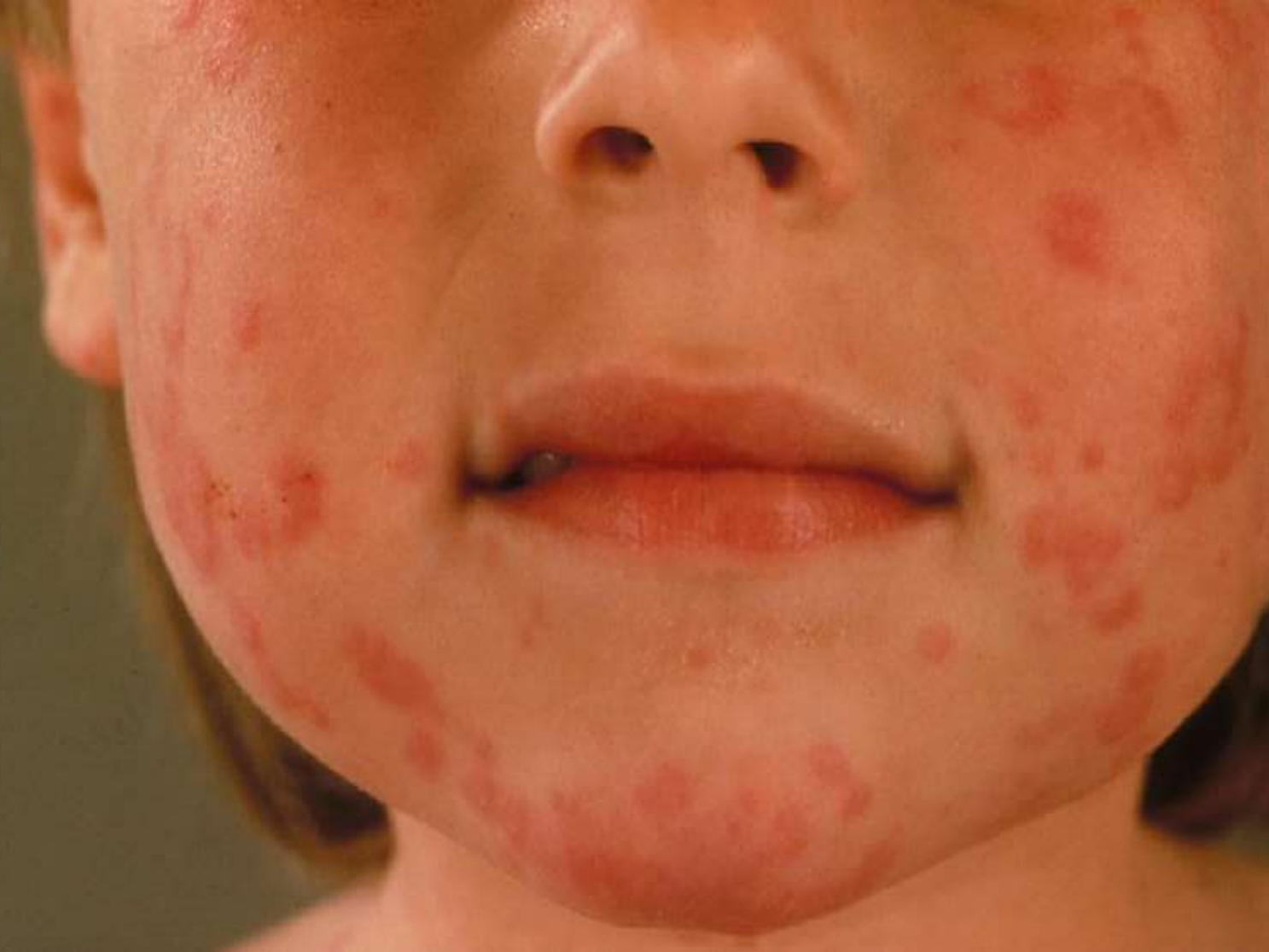












Papular Acrolocated Syndrome- Key points

- Well child
- May give history of viral disease at time of onset
- Spares trunk
- Lasts 6 weeks

Thank you!