Where's that diaphoretic should be treated. Failure to respond to treatment may be your first hint that something un-usual is happening.

Diaphoresis is the first of these zebras. The baby will present with diaphoresis in an acral distribution: hands, foot, face, and abdomen. Even though I often mention that the baby has diarrhea and is not growing as well as she should, if you suspect a zinc deficiency, look at alkaline phosphatase while you're at it. If you learn that the child has had a high alkaline phosphatase, Dr. Friedlander said. "That's why diaper dermatitis may be a clue to a clonal proliferative disorder, LCH has a wide variation in presentation and prognosis.

Dr. Friedlander described one case in which the baby had rashes in his intertriginous areas. Her first thought was Candida and, indeed, antifungals seemed to help a little bit. Adding topical steroids helped a little more, but the rashes never fully cleared. On top of that, the mother was developing some small pink papules elsewhere on the baby's body.

Upon questioning, the mother noted that the baby wasn't growing very well and also was experiencing some vomiting and diarrhea. When Dr. Friedlander did a physical exam, she noticed that the baby's liver was enlarged. (Other babies with LCH have enlarged spleens.) And those pink papules? Those were purpuric papules of petechiae.

"When you see that, you need to see Red Alert," Dr. Friedlander said. "You have scaly papules; hemorrhagic, purpuric, petechial, pustular; and paronychial involvement." LCH sometimes looks like seborrheic dermatitis, but the physician's job is to recognize it and refer the child to a pediatric oncologist.

The most common cause of diaper dermatitis is the unwieldy name "recurring toxic-medicated perianal erythema." Dr. Friedlander described one little girl with a recurring, red scaly eruption in her groin area that never responded to the typical diaper dermatitis treatments. The mother mentioned that the eruption often was accompanied by fever and a red tongue.

"Well, certainly when we see a red tongue, we think of a toxic-mediated dis- order," Dr. Friedlander said. "If the patient is febrile and looks sick, you need to get blood culture; you need to get a [sedimentation rate]. And, certainly, get cultures of the thyphal, the perianal, and esolinal skin.

Of all the zebbras, Kawasaki disease is the one you least want to miss. "If you have a child with fever and rash, and the patient is febrile and looks sick," Dr. Friedlander said. "The first hint often is a red perianal rash. Start worrying if you learn that the child has had a high fever for 4 or 5 days, has a strawberry tongue, and is unusually cranky.

The child with Kawasaki disease will often have conjunctivitis but of a specific type. The eye will not be purulent, and there won't be an exudate. And if you look closely, you may see that the conjunctivitis is sparing the limbus—the area where the cornea meets the sclera. The child also will be irritable, and the rash can be "variable. It's pretty much a polymorphous eruption, but [it doesn't] blister," Dr. Friedlander said. Two lab values can be especially note-worthy in Kawasaki disease. The C-reactive protein level will be 3 mg/dL, or higher, and the sedimentation rate will be 40 mm/hr or more. You also should order labs to rule out pyuria, meningitis, hepatitis, hyperalbuninemia, and thrombocytosis.

Diaper dermatitis, or "nappy rash," can help you identify candidates for further evaluation. Of all the zebras, Kawasaki disease is the one you least want to miss.

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