A rapidly denuding and leaving large areas of raw, red, moist skin syndrome.

Dermatologist at Geisinger Medical Center, Danville, Pa. with a mortality of up to 7%, particularly in the very young and should be identified early, said Dr. Pride, a pediatric dermatologist at Gesingher Medical Center, Danville, Pa.

The disease presents with a scarlet fever-like rash, usually beginning around the lips and nose and then becoming more generalized with flexural accentuation in the groin area; it may involve superficial bullae that rapidly denude and leave large areas of raw, red, moist skin that appears scaled. It typically occurs in children younger than 5 years.

Infections are a major cause of emergencies in pediatric dermatology, Howard Pride, M.D., said at the annual Masters of Pediatrics Conference sponsored by the University of Miami.

Though rare, such conditions must be kept in mind to ensure prompt diagnosis and appropriate treatment. Staphylococcal scaled skin syndrome, for example, is often thought to be a nondeadly disease, but it is associated with a mortality of up to 7%, particularly in the very young and should be identified early, said Dr. Pride, a pediatric dermatologist at Gesingher Medical Center, Danville, Pa.

The disease presents with a scarlet fever-like rash, usually beginning around the lips and nose and then becoming more generalized with flexural accentuation in the groin area; it may involve superficial bullae that rapidly denude and leave large areas of raw, red, moist skin that appears scaled. It typically occurs in children younger than 5 years.

Imiquimod May Clear Superficial Infantile Hemangiomas

BY SHARON WORCESTER
Tallahassee Bureau

BAL HARBOUR, Fla. — Infections are a major cause of emergencies in pediatric dermatology, Howard Pride, M.D., said at the annual Masters of Pediatrics Conference sponsored by the University of Miami.

Though rare, such conditions must be kept in mind to ensure prompt diagnosis and appropriate treatment. Staphylococcal scaled skin syndrome, for example, is often thought to be a nondeadly disease, but it is associated with a mortality of up to 7%, particularly in the very young and should be identified early, said Dr. Pride, a pediatric dermatologist at Gesingher Medical Center, Danville, Pa.

The disease presents with a scarlet fever-like rash, usually beginning around the lips and nose and then becoming more generalized with flexural accentuation in the groin area; it may involve superficial bullae that rapidly denude and leave large areas of raw, red, moist skin that appears scaled. It typically occurs in children younger than 5 years.

Imiquimod May Clear Superficial Infantile Hemangiomas

Meningococcemia is marked by rapid onset and petechial rash of skin and mucous membranes. Mupirocin is not necessary since staphylococcus is not the direct cause of the skin lesions. Strenuous attention to fluids and electrolytes is important, as is maintenance of body temperature. Antibiotic treatment against staphylococcus is useful, but a few articles have shown that some cases in adults have been associated with methicillin-resistant Staphylococcus aureus, so keep this in mind when considering antibiotic coverage, Dr. Pride advised.

"But the best thing we can do for these patients is control pain, because they are absolutely miserable," he said.

Other pediatric emergencies that Dr. Pride discussed include:

► Ecthyma gangrenosum. Lesions associated with this condition, which almost always occurs in the setting of immunosuppression, have a central hemorrhage with a purplish halo. They may have a punched-out ulcer appearance with a necrotic base and black eschar. They commonly occur in patients undergoing chemotherapy, and Pseudomonas aeruginosa is usually the culprit, Dr. Pride said. But other organisms, such as herpes simplex, S. aureus, and species of Rhodotorula, Neisseria, and Candida may be involved.

"But when you think about empirical coverage [P. aeruginosa] is the organism you really want to be covering," he said. The diagnosis is usually made clinically, and supportive measures along with a broad-spectrum antibiotic should be initiated to ensure coverage while awaiting culture or biopsy results. Aspiration or drainage of lesions should be performed as necessary.

► Meningococcemia. This is a scary and sometimes rapidly progressing disease that also requires quick action. Presentation includes high fever, headache, nausea, diarrhea, and a petechial rash of the skin and mucous membranes. The fulminant form presents with massive skin and mucosal hemorrhage, shock, and rapid death. Peripheral gangrene can occur.

Rapid antigen tests exist, but specificity is not very high, so the diagnosis should be made clinically, and treatment should be initiated quickly in an intensive care unit. Pseudomonas remains the treatment of choice for this condition, and supportive care and skin care with mupirocin are useful. Prophylaxis of patients contacts is imperative, he said.

► Rocky mountain spotted fever. The peak incidence of this often tick-borne illness, which generally occurs in the southeastern and south central United States in early summer, is in children 5–9 years old. They present with sudden severe headache, malaise, myalgia, arthralgia, anorexia, photophobia, chills, and fever. Hypotension also can occur.

A rash, which progresses centrally and mostly affects the extremities, occurs on the fourth day of illness in about 90% of patients. Early in the course of illness, the rash appears with small discrete red blanching macules, which later become papules with a dark hue. The extremities have a nonpitted edematous characteristic, and in young children the rash may occur periorbitally. About 80% of patients report a recent tick bite.

Like the other pediatric emergencies Dr. Pride discussed, this diagnosis is made clinically; good diagnostic tests are lacking.

Early treatment is important, because mortality ranges from 20% to 80% in untreated cases and is about 4% among treated cases.

Tetracyclines are the treatment of choice, with doxycycline preferred in patients younger than 8 years. Chloramphenicol is another treatment option.

Supportive care—often with intravenous hydration, supplemental oxygen and red blood cells—also is of benefit, he said.

Imiquimod May Clear Superficial Infantile Hemangiomas

Miami Beach — Topical imiquimod shows promise for clearing superficial hemangiomas in young infants, according to a small study.

Although most superficial hemangiomas involute spontaneously by the time a child reaches age 4 or 5 years, they can leave behind significant scars, atrophic changes, or deformities. Topical imiquimod (Aldara) may be an option to clear superficial infantile hemangiomas.

Four participants had complete resolution of their hemangioma, and three others had greater than 75% resolution at 16 weeks. Another participant showed moderate improvement (judged in the 50%-74% range), but was lost to follow-up after 10 weeks.

There was a treatment failure in the only infant who did not have an inflammatory response to treatment. This child may not have responded because of a receptor deficiency or poor compliance, Dr. Berman said.

"The obvious answer is the child did not use the cream, but the child may be part of the small percentage of the population that has deficient or nonfunctioning Toll-like receptor 7," the receptor is required for imiquimod activity.

Other treatment options include cryosurgery, radiation, laser therapy, corticosteroids, and interferon. Although imiquimod and interferon are both immune response modifiers, imiquimod is applied locally and thus does not carry the same risk of systemic toxicity, said Dr. Berman, a consultant for and on the speakers’ bureau of 3M, maker of imiquimod.

Other treatment options include cryosurgery, radiation, laser therapy, corticosteroids, and interferon. Although imiquimod and interferon are both immune response modifiers, imiquimod is applied locally and thus does not carry the same risk of systemic toxicity, said Dr. Berman, a consultant for and on the speakers’ bureau of 3M, maker of imiquimod.

Dr. Berman and his colleagues enrolled nine infants. Dr. Berman said at the seminar. The Skin Disease Education Foundation and this newspaper are wholly owned subsidiaries of Elsevier.

Imiquimod and interferon are both immune response modifiers, but the former is applied locally and thus does not carry the same risk of systemic toxicity.

Participant benefits include:

► Rapid antigen tests exist, but specificity is not very high, so the diagnosis should be made clinically, and treatment should be initiated quickly in an intensive care unit. Pseudomonas remains the treatment of choice for this condition, and supportive care and skin care with mupirocin are useful.

► Rocky mountain spotted fever. The peak incidence of this often tick-borne illness, which generally occurs in the southeastern and south central United States in early summer, is in children 5–9 years old. They present with sudden severe headache, malaise, myalgia, arthralgia, anorexia, photophobia, chills, and fever. Hypotension also can occur.

A rash, which progresses centrally and mostly affects the extremities, occurs on the fourth day of illness in about 90% of patients. Early in the course of illness, the rash appears with small discrete red blanching macules, which later become papules with a dark hue. The extremities have a nonpitted edematous characteristic, and in young children the rash may occur periorbitally.

About 80% of patients report a recent tick bite. Like the other pediatric emergencies Dr. Pride discussed, this diagnosis is made clinically; good diagnostic tests are lacking.

Early treatment is important, because mortality ranges from 20% to 80% in untreated cases and is about 4% among treated cases.

Tetracyclines are the treatment of choice, with doxycycline preferred in patients younger than 8 years. Chloramphenicol is another treatment option.

Supportive care—often with intravenous hydration, supplemental oxygen and red blood cells—also is of benefit, he said.

Imiquimod May Clear Superficial Infantile Hemangiomas

Miami Beach — Topical imiquimod shows promise for clearing superficial hemangiomas in young infants, according to a small study.

Although most superficial hemangiomas involute spontaneously by the time a child reaches age 4 or 5 years, they can leave behind significant scars, atrophic changes, or deformities. Topical imiquimod (Aldara) may be an option to clear superficial infantile hemangiomas.

Four participants had complete resolution of their hemangioma, and three others had greater than 75% resolution at 16 weeks. Another participant showed moderate improvement (judged in the 50%-74% range), but was lost to follow-up after 10 weeks.

There was a treatment failure in the only infant who did not have an inflammatory response to treatment. This child may not have responded because of a receptor deficiency or poor compliance, Dr. Berman said.

"The obvious answer is the child did not use the cream, but the child may be part of the small percentage of the population that has deficient or nonfunctioning Toll-like receptor 7." The receptor is required for imiquimod activity.

Other treatment options include cryosurgery, radiation, laser therapy, corticosteroids, and interferon. Although imiquimod and interferon are both immune response modifiers, imiquimod is applied locally and thus does not carry the same risk of systemic toxicity, said Dr. Berman, a consultant for and on the speakers’ bureau of 3M, maker of imiquimod.

Dr. Berman and his colleagues enrolled nine infants. Dr. Berman said at the seminar. The Skin Disease Education Foundation and this newspaper are wholly owned subsidiaries of Elsevier.

Imiquimod and interferon are both immune response modifiers, but the former is applied locally and thus does not carry the same risk of systemic toxicity.

Other treatment options include cryosurgery, radiation, laser therapy, corticosteroids, and interferon. Although imiquimod and interferon are both immune response modifiers, imiquimod is applied locally and thus does not carry the same risk of systemic toxicity, said Dr. Berman, a consultant for and on the speakers’ bureau of 3M, maker of imiquimod.

Dr. Berman and his colleagues enrolled nine infants. Dr. Berman said at the seminar. The Skin Disease Education Foundation and this newspaper are wholly owned subsidiaries of Elsevier.

Imiquimod and interferon are both immune response modifiers, but the former is applied locally and thus does not carry the same risk of systemic toxicity.

Other treatment options include cryosurgery, radiation, laser therapy, corticosteroids, and interferon. Although imiquimod and interferon are both immune response modifiers, imiquimod is applied locally and thus does not carry the same risk of systemic toxicity, said Dr. Berman, a consultant for and on the speakers’ bureau of 3M, maker of imiquimod.