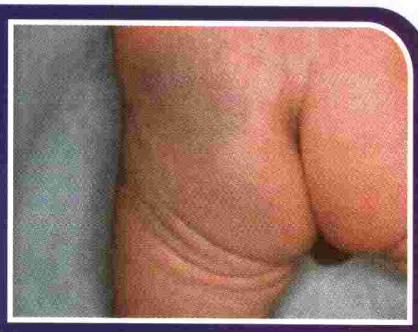
Common Skin Disorders in the Newborn

Common skin disorders in the first month of life include Mongolian spots, erythema toxicum, cafe au lait, hemangiomata, seborrhoeic dermatitis, infantile atopic dermatitis, melanocytic nevi, nevus sebaceum and hypomelanosis of Ito.

Mongolian Spots

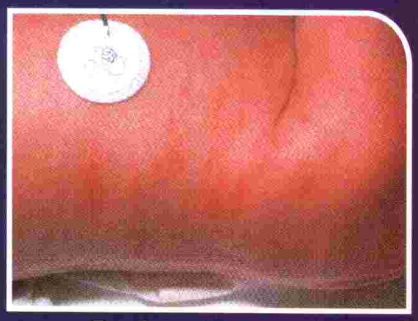
Blue to black in colour, these flat patches indicate a persistence of dermal melanocytes. They are seen in about 70% of oriental infants, particularly over the lower back, but can occur over limbs or face. They disappear with time. They should be differentiated from bruises.



Mongolian Spots

Erythema Toxicum

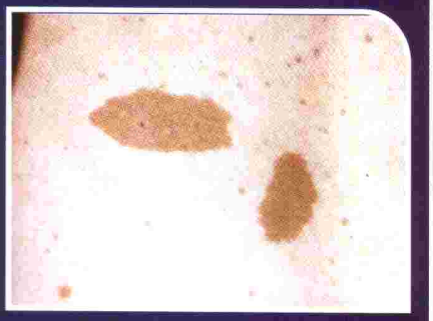
This is the commonest eruption in the neonate that usually appears on the second or third day of life. The discrete lesions may be scanty or extensive, are erythematous, and may be maculopapular or pustular, with surrounding erythema. Lesions show many eosinophils and there may be blood eosinophilia. Lesions may persist for hours or days but is self-limiting.



Erythema Toxicum

Café-Au-Lait Patches

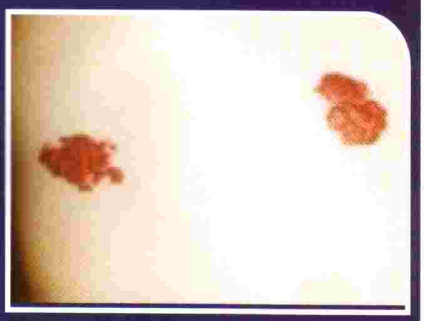
These well-defined macules are seen in healthy children often as single lesions. The presence of 6 or more lesions measuring > 0.5 cm in diameter should lead to suspicion of neurofibromatosis type 1 (NF-1). Solitary or multiple café-au-lait patches may be associated with NF-2, McCune-Albright syndrome, ring chromosome syndromes and Watson's syndrome. Histopathology of patches reveals increased melanin in both melanocytes and basal layer keratinocytes.



Café-Au-Lait Patches

Strawberry Haemangioma (capillary haemangioma)

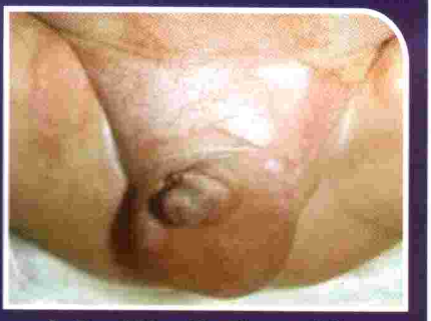
These occur in 10–12% of infants, often in prematurely born babies. They usually appear in the first month of life rather than at birth, grow for 8–18 months and then resolve completely over the next 5 – 8 years. If associated with a deeper portion, they are called mixed haemangiomas. They may be associated with bleeding, infection, Kasabach Merritt syndrome (causing coagulopathy) and high-output cardiac failure if large.



Strawberry Haemangioma (capillary haemangioma)

Irritant Napkin Dermatitis

This frictional dermatitis typically occurs from 2 months old onwards, aggravated by prolonged duration of skin contact with urine in wet nappies. It typically involves skin convexities (unlike flexural infantile seborrhoeic dermatitis). Erythema and scaling are the striking features. Erosive lesions may be seen. Occasionally a vesicular form simulating herpes simplex infection occurs. Treat by exposing the skin. Emollients and mild steroid applications are also important.



Irritant Napkin Dermatitis

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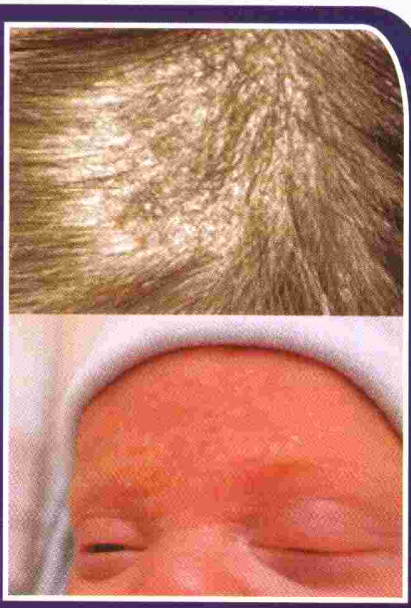
Infantile Seborrhoeic Dermatitis

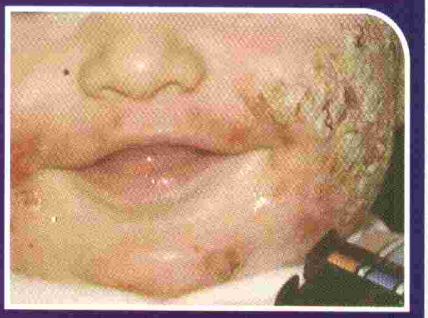
This non-irritant condition often occurs in the newborn, persisting for a few weeks only. There is an increased incidence of atopic dermatitis in those who develop infantile seborrhoeic dermatitis. Affected areas are often the napkin areas, groins, scalp, axillae and post-auricular regions. Axillary involvement in seborrhoeic dermatitis distinguishes it from atopic dermatitis. There is erythema, maceration and scaling of skin folds, sometimes becoming more widespread over the trunk and face. Manifestation ranges from a yellow greasy scalp scaling (cradle cap) to generalized erythroderma (requiring in-patient treatment). Candidal and bacterial infection can complicate. Treat infantile seborrhoea with an imidazole such as miconazole 2% cream in combination with hydrocortisone. Shampoo hair vigorously and frequently (preferably daily). Loosen scales with the fingers, scrub for at least 5 minutes, and rinse thoroughly. Active ingredients in these shampoos include salicylic acid, coal tar, zinc, resorcin, ketoconazole, or selenium.



Infantile Seborrhoeic Dermatitis

Infantile Atopic Dermatitis

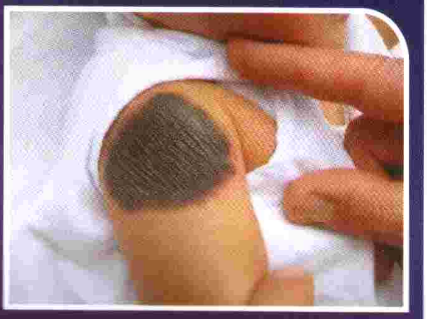
This common inherited condition usually appears in the third month of life or later. It is typically irritant and erythematous, with papules and vesicles appearing over the forehead and scalp. There may be a family history of asthma, atopic dermatitis or allergic rhinitis. Advise to wear cotton clothing, use perfume-free soap and apply plenty of moisturiser several times a day. If uncontrolled with a moisturiser, treat with a steroid. Exercise caution when using > 1% hydrocortisone cream on infants and avoid steroid creams on the face, where skin is thin, if possible.



Infantile Atopic Dermatitis

Melanocytic Nevi

Lesions with malignant potential are congenital melanocytic naevus and naevus sebaceum. Small (< 5 mm), medium (5 – 20 mm) and giant (> 20 mm) melanoytic naevi may occur, with a giant naevus having a 6 - 8% risk of transforming into malignant melanoma.



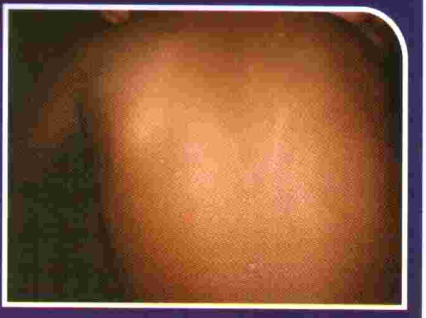
Melanocytic Nevi

Naevus Sebaceum

Naevus sebaceum is a pilosebaceous gland malformation, presenting at birth as a circumscribed yellowish hairless plaque, which becomes warty during puberty. They have a 5% risk of basal cell carcinoma. Treatment is excision before puberty, or better, before six months of age, as healing would be better.

Hypomelanosis of Ito

Hypomelanosis of Ito produces small (0.5-1 cm) asymmetric pale or white patches of skin, merging to form larger patches or whorls. It may be associated with birth defects such as cleft palate, limb, hand, foot or face abnormalities, mental retardation or seizures. No treatment is necessary. Over time, the skin may develop pigment and blend in with normal adjacent skin.



Hypomelanosis of Ito