

Diagnosis at a Glance

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CASE 1

A mother seeks consultation for her 3-year-old daughter, who presents with an extensive, mildly pruritic rash on her face, trunk, and extremities. The child is of Hispanic ethnicity but has never traveled abroad. No other family members are affected with the condition. Family history is positive for eczema and seasonal allergies. Patient's mother denies recent history of fever, chills, vomiting, or diarrhea, and states the child is up-to-date on all immunizations. Examination reveals multiple hypopigmented macules of the affected areas. A dermatology consult is ordered for punch biopsy.

What is your diagnosis?



CASE 2

A mother seeks evaluation for her 4-year-old daughter, who presents with an itchy lesion on her ankle that developed 2 days before consultation. She states that the lesion appeared red at onset and rapidly evolved into a blister. There is no history of insect bite or recent outdoor activities. The patient's two older siblings are not affected, and all children are up to date on immunizations. The child is afebrile and in good spirits. Examination of the ankle reveals a flaccid bulla on a slightly erythematous base. No other lesions are noted elsewhere.

What is your diagnosis?

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adverse reactions in nursing infants from rivaroxaban, a decision should be made whether to discontinue nursing or discontinue XARELTO, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in pediatric patients have not been established.

Geriatric Use: Of the total number of patients in the RECORD 1-3 clinical studies evaluating XARELTO, about 54% were 65 years and over, while about 15% were >75 years. In ROCKET AF, approximately 77% were 65 years and over and about 38% were >75 years. In the EINSTEIN DVT, PE and Extension clinical studies approximately 37% were 65 years and over and about 16% were >75 years. In clinical trials the efficacy of XARELTO in the elderly (65 years or older) was similar to that seen in patients younger than 65 years. Both thrombotic and bleeding event rates were higher in these older patients, but the risk-benefit profile was favorable in all age groups [see *Clinical Pharmacology (12.3) and Clinical Studies (14) in full Prescribing Information*].

Females of Reproductive Potential: Females of reproductive potential requiring anticoagulation should discuss pregnancy planning with their physician.

Renal Impairment: In a pharmacokinetic study, compared to healthy subjects with normal creatinine clearance, rivaroxaban exposure increased by approximately 44 to 64% in subjects with renal impairment. Increases in pharmacodynamic effects were also observed [see *Clinical Pharmacology (12.3) in full Prescribing Information*].

Nonvalvular Atrial Fibrillation: In the ROCKET AF trial, patients with CrCl 30 to 50 mL/min were administered XARELTO 15 mg once daily resulting in serum concentrations of rivaroxaban and clinical outcomes similar to those in patients with better renal function administered XARELTO 20 mg once daily. Patients with CrCl 15 to 30 mL/min were not studied, but administration of XARELTO 15 mg once daily is also expected to result in serum concentrations of rivaroxaban similar to those in patients with normal renal function [see *Dosage and Administration (2.3) in full Prescribing Information*].

Treatment of DVT and/or PE, and Reduction in the Risk of Recurrence of DVT and of PE: In the EINSTEIN trials, patients with CrCl values <30 mL/min at screening were excluded from the studies. Avoid the use of XARELTO in patients with CrCl <30 mL/min.

Prophylaxis of DVT Following Hip or Knee Replacement Surgery: The combined analysis of the RECORD 1-3 clinical efficacy studies did not show an increase in bleeding risk for patients with CrCl 30 to 50 mL/min and reported a possible increase in total venous thromboemboli in this population. Observe closely and promptly evaluate any signs or symptoms of blood loss in patients with CrCl 30 to 50 mL/min. Avoid the use of XARELTO in patients with CrCl <30 mL/min.

Hepatic Impairment: In a pharmacokinetic study, compared to healthy subjects with normal liver function, AUC increases of 127% were observed in subjects with moderate hepatic impairment (Child-Pugh B).

The safety or PK of XARELTO in patients with severe hepatic impairment (Child-Pugh C) has not been evaluated [see *Clinical Pharmacology (12.3) in full Prescribing Information*].

Avoid the use of XARELTO in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic impairment or with any hepatic disease associated with coagulopathy.

OVERDOSAGE:

Overdose of XARELTO may lead to hemorrhage. Discontinue XARELTO and initiate appropriate therapy if bleeding complications associated with overdose occur. A specific antidote for rivaroxaban is not available. Rivaroxaban systemic exposure is not further increased at single doses >50 mg due to limited absorption. The use of activated charcoal to reduce absorption in case of XARELTO overdose may be considered. Due to the high plasma protein binding, rivaroxaban is not expected to be dialyzable [see *Warnings and Precautions and Clinical Pharmacology (12.3) in full Prescribing Information*].

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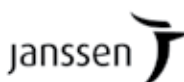
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ANSWER

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CASE 1

Pityriasis alba, a benign condition in children and young adults, is characterized by the appearance of annular to oval macules distributed on the lateral upper arms, thighs, or face, or on multiple locations. The disorder may be accompanied by xerosis and scale, and is associated with atopy. Asymptomatic pityriasis alba often presents as an incidental finding on physical examination. Differential diagnosis includes vitiligo and tinea versicolor; secondary syphilis and hypopigmented mycosis fungoides might warrant consideration. Biopsy was performed in this case based on the extent of the lesions and the parent's concern. The disease is self-limiting but can persist for months; topical steroids and topical calcineurin inhibitors may hasten resolution.

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CASE 2

Impetigo is a common bacterial infection that occurs on exposed areas of skin, such as the face and extremities. The majority of cases are of the nonbullous type, characterized by the appearance of crusted, honey-colored lesions associated with a serous exudate. This child's lesion, however, is an example of bullous impetigo, in which the blister is superficial and fragile. The localized tissue reaction is caused by an exfoliative toxin released by staphylococci. Diagnosis is based on history and clinical appearance. A solitary ruptured bulla of this nature is treated with gentle cleansing and a topical antibiotic, such as mupirocin.