Other Conditions May Mimic Diaper Dermatitis

BY ROBERT FINN

SAN FRANCISCO — Don't ignore a seemingly simple case of diaper dermatitis, because this near-ubiquitous condition can mask something much more serious.

In fact, there are at least four "zebras" whose hoof beats may be sounding in diaper dermatitis, Dr. Sheila Fallon Friedlander said at a meeting sponsored by Skin Disease Education Foundation.

That's why diaper dermatitis should be treated. Failure to respond to treatment may be your first hint that something unusual is happening.

Zinc deficiency is the first of these zebras. The baby will present with dermatitis in an acral distribution: hands, feet, face, and genitals. The parent will 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 waiting for zinc levels to come back from the lab. A low alkaline phosphatase level should make you suspicious of zinc, said Dr. Friedlander of the University of California, San Diego.

Langerhans cell histiocytosis (LCH) is the next zebra. Thought by many to be a clonal proliferative disorder, LCH has a wide variability 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 bit more, but the rashes never fully cleared. On top of that, the mother was noticing 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 lesions; 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 third zebra goes by the unwieldy name "recurrent toxin-mediated perineal erythema." Dr. Friedlander described one little girl with a recurrent 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 toxin-mediated disorder," 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 pharynx, the perianal area, and lesional skin."

Of all the zebras, Kawasaki disease is the one you least want to miss. "If you recognize it early, you can save a life," 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 crabby.

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 may have cervical lymphadenopathy, 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 noteworthy 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, hypoalbuminemia, and thrombocytosis.

Dr. Friedlander disclosed serving as a consultant and a researcher for Barrier Therapeutics Inc., which makes a prescription ointment for diaper rash.

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