Steroids for Hemangiomas Don't Jeopardize Height

BY HEIDI SPLETE
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CHICAGO — Short-term treatment with oral corticosteroids doesn't appear to prevent infants with hemangiomas from achieving normal height, based on data from a study of 44 children with infant hemangiomas who were treated with corticosteroids for an average of 14 months.

All but two children (95%) had grown to within two standard deviations of their predicted normal heights by the time they were approximately 5 years old. The predicted normal heights were based on the average midparental height, which is a formula for predicting a child's normal adult height based on the heights of both parents. For the general population, the expected future height falls within two standard deviations of the midparental height.

"Our research question was whether short-term corticosteroids impacted long-term growth," said Dr. Perla Lansang, who presented the findings at the annual meeting of the Society for Pediatric Dermatology.

The efficacy of treating large infant hemangiomas with oral corticosteroids has been well documented, but short-term growth retardation is a common side effect and the potential for long-term growth retardation remains a concern, said Dr. Lansang, a dermatologist who conducted the study at the Hospital for Sick Children, Toronto, as part of a resident research award from the society.

The study population included 8 boys and 36 girls with hemangiomas who were treated with oral corticosteroids at the hospital between January 2000 and December 2005. Children with other metabolic conditions or those who were taking corticosteroids for other reasons were excluded. The children started taking oral corticosteroids at an average of 3 months of age, and the average dosage was 2.2 mg/kg per day. Although all the children experienced growth retardation while taking the steroids, the steepest drop off the growth curve occurred primarily during the first 3 to 4 months of treatment, Dr. Lansang noted.

The children's growth resumed after an average of 8 months of treatment, but the most rapid increase in catch-up growth occurred during the first 2 years after the children stopped taking corticosteroids. The mechanism of action for growth velocity patterns after the discontinuation of steroid use is not well understood, but by the end of the study most of the children were on track to achieve their normal height based on midparental height, Dr. Lansang said. The findings may ease clinicians' and parents' concerns about long-term growth outcomes for these children. ■

AD Therapy: Tips for Getting Teens to Comply

CHICAGO — Assume noncompliance when treating atopic dermatitis in teenage patients, said Dr. Jon M. Hanifin, a dermatologist at Oregon Health and Science University in Portland.

"Managing atopic dermatitis in teenagers is not for the faint of heart," said Dr. Hanifin, a specialist in atopic dermatitis who has served as a consultant for multiple pharmaceutical companies.

Dr. Hanifin shared some tips on treating atopic dermatitis (AD) in teenagers at the annual meeting of the Society for Pediatric Dermatology, including these:

► Keep the parents out of the room except for the start and end of the visit. "You have to get the parents out of the room to find out what's going on," he said.

► Ask the teens to call the office if the treatment isn't going well and encourage them to schedule their appointments.

► Offer psychiatric consultation. Some of these teens genuinely want some help other than their parents yelling at them.

► Don't shy away from systemic medications. Try methotrexate for moderate to severe cases of AD in adolescents because it is less expensive than cyclosporin, Dr. Hanifin said. He often starts teen atopic dermatitis patients with 2.5 mg of methotrexate for 4 of 7 days each week, which has been more effective than a once-weekly dose of 15 mg in many of his teen patients.

But clinicians must remember that making time for consistent AD care is rarely a priority for a busy teenager, he noted.

—Heidi Splete

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