Some Adult Skin Problems Affect Children, Too

BY DOUG BRUNK
San Diego Bureau

LAS VEGAS — You may think of perioral dermatitis as an adult-only disease, but it affects children as well, Patricia M. Witman, M.D., said at a dermatology seminar sponsored by the Skin Disease Education Foundation.

The exact incidence of perioral dermatitis in children is unknown, said Dr. Witman of the Mayo Clinic, Rochester, Minn. It tends to occur in prepubertal children but can also affect those as young as 7 months. The adult form of the disease usually favors women, whereas in children, it is seen with equal frequency in boys and girls.

"It can have a perioral distribution, but periocular and perinasal lesions are also common," Dr. Witman said.

Although the cause is unknown, the disease may manifest from genetic inheritance, corticosteroids, fluoride in toothpaste, cosmetics, and certain ingredients found in chewing gum.

Treatment requires antibiotics "and some patience," she said. For mild cases, Dr. Witman usually recommends topical metronidazole. "Sometimes I'll use it in a lotion form if I'm starting it on a child with sensitive skin that may be irritated," she said.

Other topical options include erythromycin and sodium sulfacetamide.

If the disease is more inflammatory or if the lesions are granulomatous, Dr. Witman recommends using systemic antibiotics. Erythromycin and amoxicillin are the typical choices for children 8 years or younger; tetracycline is an option for older children.

In childhood granulomatous periorificial dermatitis, a variant of perioral dermatitis, "inflammation is more intense, and one can almost see granulomatous or infiltrativelike lesions in a similar distribution to that seen in the more common variant," she said.

Perioral dermatitis can affect those as young as 7 months. While the adult form favors women, the pediatric form is seen equally in girls and boys.

This variant tends to affect prepubertal children and can involve nonfacial sites such as the scalp, trunk, extremities, and the genitals.

Histology often reveals more inflammation and actual granuloma formation, compared with that seen in the common form of perioral dermatitis.

Dr. Witman discussed other adult skin diseases that can affect children:

▶ **Rosacea.** The exact incidence is unknown in children, but it tends to affect those with fair skin. Of these, an estimated 20% will have affected parents, "suggesting a genetic relationship," she said.

So-called steroid rosacea is the most common type. "These are usually kids who have been treated with topical steroids for another reason and then develop the eruption," she explained. "They can have the typical things that they expect to see in the adults: flushing, erythema, pustules, telangectasias."

Rosacea can be treated with the same topical and oral agents used for perioral dermatitis.

"Treatment response is usually excellent, but occasionally you will have patients who have a chronic course," Dr. Witman said.

Ocular involvement is common, and Dr. Witman advises sending children to an ophthalmologist if the disease persists.

▶ **Rosacealike demodicosis.** This skin eruption looks like rosacea but is thought to be aggravated by the Demodex mite. "It's quite controversial whether the Demodex mite really causes this disease or not, but there appear to be some situations where Demodex mites may multiply and actually cause a facial eruption that looks very much like rosacea," she said.

Cases of rosacealike demodicosis have been noted in immunosuppressed children and those on maintenance chemotherapy for acute lymphoblastic leukemia.

Treatment options include permethrin cream, metronidazole gel, or oral erythromycin.

▶ **Schamberg's disease.** This skin discoloration, also known as progressive pigmentary purpura, "can cause a lot of anxiety for parents," Dr. Witman said.

Differential diagnoses include drug-induced capillaritis, trauma- or self-induced purpura, leukocytoclastic vasculitis, benign hypergammaglobulinemic purpura of Waldenstrom, and cutaneous T-cell lymphoma.

The incidence of Schamberg's in children is unclear. In a recently published series of 13 cases of the disease in children aged 1-9 years, most were female, and the most common location of disease was the legs, mainly the distal lower extremities (J. Am. Acad. Dermatol. 2003;48:31-3). The disease can also present on the trunk and the arms.

Three of the children had a unilateral distribution, all of them had normal lab studies, and one-third had fading of their lesions in 1-4 years. One patient still had disease after 7 years.

Dr. Witman recommends reassuring patients that their lesions will clear with time. "There are reports of the use of systemic steroids and PUVA therapy that can clear these conditions, but because this is a chronic condition and those therapies carry some risks, I often just reassure patients," she said.

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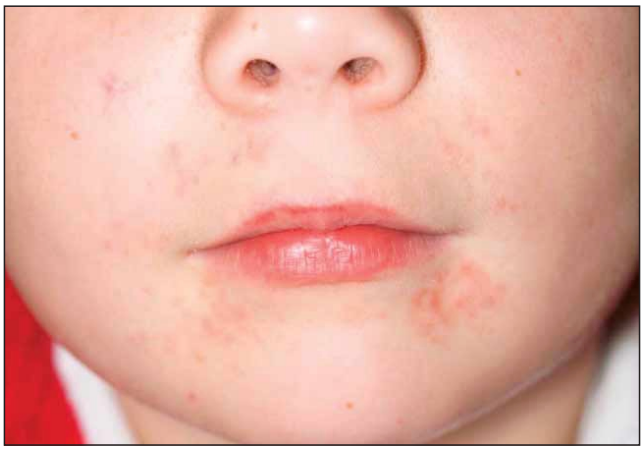

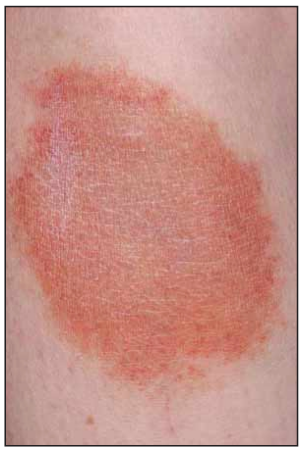

PHOTOS COURTESY DR. PATRICIA M. WITMAN

Perioral dermatitis (left) is often misdiagnosed in children. When treated with medications like topical steroids, it only worsens. Schamberg's disease, also called progressive pigmentary purpura (right), is a chronic condition.

Add Topical to Oral Antifungal to Treat Childhood Ringworm

BY NORRA MACREADY
Los Angeles Bureau

NEWPORT BEACH, CALIF. — Tinea capitis is the most common dermatophytic infection of childhood, Sheila Fallon Friedlander, M.D., said at the annual meeting of the Pacific Dermatologic Association.

She answered common questions posed by primary care physicians about the condition:

▶ **Which organisms are most likely to cause tinea capitis?** In the United States, *Trichophyton tonsurans* accounts for most cases, said Dr. Friedlander, a pediatric dermatologist at the University of California, San Diego, Healthcare system. *Microsporum canis* is occasionally seen, and usually is transmitted from a household pet.

However, in other countries, other organisms may cause tinea capitis, which is something to keep in mind when examining a child who immigrated from abroad, has recently traveled abroad, or who was adopted from a foreign country.

▶ **What is the treatment of choice?** Treatment should consist of oral griseofulvin plus a topical antifungal agent. Dr. Friedlander recommends starting griseofulvin at a dose of 20 mg/kg, which is higher than the standard dose but produces the best cure rates. A lower dose is "an inappropriate treatment for tinea capitis," she said.

Evidence is accumulating that terbinafine (Lamisil), given at 3-6 mg/kg, is as safe and effective as griseofulvin and acts within 2 weeks. Enhanced efficacy has been seen with higher dosing of terbinafine (5-8 mg/kg per day). Some studies have documented good response with itraconazole (Sporanox) and fluconazole (Diflucan).

▶ **How long should treatment last?** In her practice, Dr. Friedlander usually treats for 8 weeks. Many experts recommend treating until 2 weeks after resolution of symptoms, which may require weeks to months of therapy.

▶ **What do you tell parents about griseofulvin?** Griseofulvin is inexpensive and has a long track record of efficacy. It is a relatively safe drug, but about 30% of patients develop side effects that include headache, gastrointestinal upset, and photosensitivity.

▶ **Are laboratory tests necessary?** Lab tests are needed only if the patient requires more than 8 weeks of treatment.

▶ **Do you treat the entire family?** Ask about other family members and treat them if they are symptomatic. *T. tonsurans* is commonly passed among wrestlers. Infection with *M. canis* should lead to questions about the family pet, as cats and dogs frequently harbor these organisms.

Some family members may insist on treatment even when they are asymptomatic. Dr. Friedlander prescribes topical therapy to reassure them.

▶ **Do you prescribe prednisone for kerions?** Most patients don't need prednisone. Kerions (nodular, exudative, circumscribed tumefactions covered with pustules) usually respond to antifungal therapy.

"We recommend adjunctive topical antifungal therapy, but rarely utilize the systemic therapy," Dr. Friedlander said. If the patient doesn't improve within 2 weeks, Dr. Friedlander said she will add systemic therapy, but in most cases that isn't necessary. ■