Pediatric Dermatology Referral Guidelines and suggestions for initial care

Below recommendations do not substitute for your clinical judgement and should be taking into consideration the context of individual cases. Many of the treatment considerations listed below are "off label" due to the paucity of trials for pediatric dermatology conditions.

Atopic dermatitis

Notes:

Please see "Eczema in a Nutshell"

Nevus/Mole

Notes:

- Pediatric melanoma is fortunately very rare
- Scalp nevi are often larger than typical nevi and may have eclipse pattern
- Congenital nevi are often much bigger than acquired nevi
- Melanoma in prepubertal children may present as amelanotic bleeding papules
- Melanonychia striata in children fortunately usually benign

Referral to dermatology is indicated when:

- Nevus has unexpected change, esp in relatively short period of time
- Nevus becomes friable and bleeds easily
- Large or Giant congenital melanocytic nevus (>20cm predicted adult size)

Warts

Notes: Multi-modal approach and a lot of patience is usually required

- Salicylic acid application daily, such as Soluver Plus
- Topical retinoids, such as tretinoin may be useful for flat warts esp on face
- Topical imiquimod or sinecatechins may be useful for condylomata acuminata
- Cryotherapy with liquid nitrogen for older children who can tolerate the procedure
- Paring with 10 or 15 made scalpel can be followed by application of silver nitrate (note: may leave stain on skin) prior to liquid nitrogen and/or OTC salicylic acid
- Cantharidin can be applied painlessly, covered with band-aid/tape then washed off after 2-4 hours (note: increases risk of ring wart development)
- For multiple recalcitrant warts, consider checking zinc level and supplementation

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Referral to dermatology is indicated when:

- In immunosuppressed patient (e.g., post-transplant)
- Multiple, severe, refractory and visible causing social stigma

Molluscum Contagiosum

Notes:

- Will resolve eventually and so families can be reassured
- May leave small, pitted scars especially if very large
- May become inflamed just prior to resolution (BOTE beginning-of-the end sign)
- Many respond spontaneously without treatment over the course of 6 weeks-2 years
- Cantharidin can be applied painlessly, cover with Band-Aid/tape then washed off after 2-4 hours (note: may induce blistering reaction so only a few should be treated at first visit)
- Liquid nitrogen can be used but will be painful, especially for young children (note: only 2-3 seconds per cycle required for molluscum)
- At home remedies include vinegar, tea-tree, and hydrogen peroxide have limited evidence but might be modestly helpful
- Imiquimod generally be more irritating than beneficial
- Topical retinods can be trialed as mild irritant

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Vitiligo

Notes:

- Response to treatment is very slow and lower in areas with white hair or little hair
- Body: Tacrolimus 0.03/0.1% ointment daily Monday to Friday, Clobetasol daily on weekend
- Face: Tacrolimus 0.03/0.1% ointment daily
- Bloodwork can be checked as needed based on history because vitiligo is associated with several autoimmune conditions: CBC, fasting glucose, TSH

Referral to dermatology is indicated when:

- No improvement with above treatment for at least 6 months and significant social impact
- Involving >10% of body surface area

Psoriasis

Notes:

- General treatments can be started for body areas:
  - Mid-high potency corticosteroids such as mometasone and clobetasol or
  - Topical vitamin D derivatives (Calcipotriene) ointment alone or in combination with betamethasone dipropionate (Dovobet/Enstilar)
- For thick scales:
  - Betamethasone dipropionate with salicylic acid
- For face and genital region:
  - Topical tacrolimus or pimecrolimus
- For scalp:
  - Fluocinolone acetonide oil for mild scalp involvement
  - Betamethasone valerate or clobetasol scalp lotion for thicker scalp involvement
- Monitor for co-morbidities: arthritis, metabolic issues, psychosocial impact

Referral to dermatology is indicated when:

- No improvement with above treatment
- Involving >10% of body surface area
- Rapid progression

Infantile hemangioma

Notes:

- Routine infantile hemangiomas will go through growth phase, stabilize, then resolve without causing any challenges
- Risks associated with hemangiomas include threatening function such as vision; ulceration; and potential disfigurement
- Congenital hemangiomas (present from birth without growth phase) and pyogenic granulomas (present later in life and frequently bleed) are distinct entities requiring different approaches

- Small facial hemangiomas **not** at risk of disfigurement can be treated with topical timolol 0.5% applied 1 drop twice daily

Referral to dermatology should be done early, will be prioritized as “urgent,” and is indicated when:

- Location in cosmetically sensitive areas and may result in deformity (such as on the face (especially the nose), lip, ear, or breast)
- Potential to interfere with function (such as periorbital interfering with vision or around the mouth that impacts feeding)
- Large, deep, or ulcerated hemangiomas
- Patients at risk for PHACES or LUMBAR syndrome (segmental hemangiomas on head and neck or in pelvic region respectively)
- Abdominal ultrasound recommended if more than 5 infantile hemangiomas

Acne

Notes:

- **Mild acne:** over-the-counter topical therapy such as salicylic acid or benzoyl peroxide washes, creams, and wipes
    - Primarily comedonal acne: topical retinoids
    - Small inflammatory lesions: benzoyl peroxide, topical antibiotics, or combination products
    - Mixed comedonal and inflammatory acne: combination of both topical retinoid and antibiotic such as adapalene/benzoyl peroxide, tretinoin/clindamycin, tretinoin/benzoyl peroxide
- **Moderate acne:** may require oral therapy in combination with topical therapy as above
    - Papular/pustular acne: oral antibiotics such as doxycycline taken for several months
    - Combined oral contraceptive pill in combination with topical products may be effective for female patients
- **Severe, scarring, or unresponsive acne:**
    - Isotretinoin – may require pre-treatment with oral steroids or oral antibiotics to prevent flare of acne fulminans at initiation of isotretinoin

Referral to dermatology is indicated when:

- No improvement with topical therapy and/or antibiotics or contraindications to their use

- Severe scarring presentation
- Significant social impact - such as missing school

Alopecia areata

Notes:

- Alopecia areata can be very impactful for children and adults alike and should not be minimized. Psychosocial supports may be needed, particularly if stress is trigger.
- Children with alopecia areata rarely tolerate intralesional injections.
- Topical steroids can be utilized as an alternative. One possible protocol is clobetasol scalp lotion daily for 3 weeks on/1 week off
- New hair growth is often very fine and light in color (vellus hairs)
- Topical minoxidil can be utilized as adjunct therapy esp. once vellus hairs are visible.
- Screening for other autoimmune conditions such as thyroid disease and diabetes should be based on symptoms.

Referral to dermatology is indicated when:

- Alopecia is severe and diffuse
- Systemic therapies are under consideration

Scabies

Notes:

- All contacts will need to be treated concurrently – not only those that have symptoms
- Scabies mites are visible with dermoscopy at the end of a burrow (delta wing sign)
- Ensure adequate medication is provided for all family members
- Treatment failures are often due to close contact who was not treated
- Post-scabetic itch is not treatment failure and can be expected to last several weeks. This can be treated with betamethasone valerate.

Routine treatment protocol:

- Permethrin 5% at bedtime from neck down for all over 2 years old and whole body for those under 2 years old. Care to apply beneath nails and in genital area.
- Bathe in AM to wash off permethrin
- Launder all linens – sheets, towels, pillow cases – and all clothes that have been worn in past 3 days.

- General house cleaning – set aside stuffies and other non-washable items for 3 days
- Repeat in 1 week

Treatment alternatives:
- Oral ivermectin for those >15kg
- Precipitated sulfur 8% in Petrolatum – applied all over and left on for 24hrs then rinsed and reapplied for 3 days total. Launder and house cleaning as above.

Referral to dermatology is indicated when:
- Lack of response to therapy despite above
- Concerns of crusted scabies

Hand Foot and Mouth

Notes:
- Buttock is common location for lesions
- More widespread involvement on arms and legs is more common now due to A6 strain of coxsackie virus
- Extensive lesions can be seen in patients with eczema (eczema coxsackium)
- Enterovirus can be picked up on viral swabs sent for PCR
- Onychomadesis may occur in the months following hand-foot-and mouth, and presents with lifting of the proximal nail

Referral to dermatology
- Rarely needed, only with very severe presentation or unclear diagnosis

Tinea corporis

Notes:
- Fungal infections of hair and nails generally require oral therapy (though mild nail involvement might respond to topical therapy such as efinaconazole over many months)
- KOH and fungal culture are helpful in documenting fungal infections when the diagnosis is not clear and can be sent even if starting empiric therapy
- Nummular eczema is often misdiagnosed as tinea corporis
- Treating with topical steroids may bring temporary improvement in tinea corporis, but over time leads to worsening infection including possible fungal folliculitis

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