Editorial

Lessons Learned in Pediatric Dermatology Practice

Nanette B. Silverberg, MD

Over time I have learned much from teachers, mentors, and medical literature for which I am grateful. While practicing medicine, I have learned some lessons of my own, 3 of which I will share.

1. No matter how many patients you see, you will never get to the point where you have seen everything.

As a resident, I recall an attending physician in his 90s being rolled in by wheelchair to grand rounds and providing his occasional comments with a strong sense of humility, stating at times that he had never seen anything quite like the patients shown. I think the enthusiasm he channeled at grand rounds after 70 years of practice was partially driven by a dermatologist's fascination with viewing things that have never been seen before, which is one of the most exciting features of dermatology practice. Recognition of new trends and new diagnoses is part of what drives academicians throughout their career.

The downside is that as a practitioner you will never see or experience all the possible forms of unusual behaviors displayed by patients (psychocutaneous medicine). In pediatric dermatology, children often are accompanied by multiple senior family members, including parents and grandparents. Therefore, skin disease of childhood often is affected by the psychological state of parents and grandparents. One example comes to mind from a recent experience. A 13-year-old adolescent girl with extensive vitiligo saw me for a depigmentation consultation. When I sent the patient and her parents for psychological screening, both the patient and her mother failed due to psychological instability in both the mother and daughter. This was a first!

2. Picture yourself in the last physician's shoes.

When a patient complains about his/her former practitioner, occasionally it is warranted, but sometimes it is forme fruste of the patient's or parent's interpersonal difficulties. A bizarre story that comes to mind involves a New York mother who said her child had been bitten by bugs while visiting grandparents in Texas. The child was diagnosed with bedbug bites by a Texas pediatric dermatologist quite accurately, but the mother was unsatisfied because she did not feel the doctor had adequate entomologic experience. A few weeks later the mother called and was hysterical about having found a bedbug in her home. I asked her to leave the specimen for me to view. The specimen came with a 2-page history of her child's symptomatology and bug sightings, a blow-by-blow account over 48 hours. The bag contained one shriveled bug and some round brown specimens that appeared very odd under the microscope. When I called the mother to talk to her about my microscopy, she admitted she had thrown some seeds from her bread in the bag with the bug to test my entomology skills. She took me for a walk in the same shoes.

3. Trust your teachers.

As a fellow, my teachers had instructed me on proper cantharidin usage and warned against treatment of more than 20 molluscum lesions due to possible induction of an id reaction. At one American Academy of Dermatology meeting a few years ago, a colleague told me she had never induced id reactions when treating as many as 30 to 50 molluscum lesions. Of course I treated all 30 lesions on the next pediatric patient with molluscum, and of course she developed an id reaction promptly after therapy. I hate to say it, but they (my teachers) told me so; listen to their treatment pearls!

From the Department of Dermatology, St. Luke's-Roosevelt Hospital Center, New York, New York; Beth Israel Medical Center, New York; and Columbia University College of Physicians and Surgeons, New York.

The author reports no conflict of interest.