

Iatrogenic NICU Injuries Often Overlooked, Scarring Is Likely

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SAN FRANCISCO — Iatrogenic injuries to a baby's skin from a stay in the neonatal intensive care unit often get overlooked until parents notice them at home and think they are seeing new injuries, Dr. Ilona J. Frieden said.

"These are very 'busy' babies, covered with monitors, and they're very tiny" babies, she said at a meeting sponsored by Skin Disease Education Foundation. Many things that are used on preterm babies can cause skin injury or scarring, such as tape, electrodes, transcutaneous monitoring devices, adhesives, and cleansers. Phototherapy can sunburn their fragile skin, and infusions and blood draws cause punctures and possible scars.

"A majority of infants who come out of the premature NICU will have some degree of minor skin scarring. You can almost expect it. The more preterm they are, the more likely this is," said Dr. Frieden, professor of dermatology and pediatrics at the University of California, San Francisco.

Later in infancy, after discharge from the hospital, parents may notice what they think is a new lesion. "People get worried this may be a new rash, when in fact, it's a so-called anetoderma of prematurity," she said. These atrophic lesions, usually on the ventral skin, initially can be progressive, and then stabilize.

Another iatrogenic injury seen in preterm infants is halo scalp injury—a temporary or permanent alopecia, usu-

ally in the occipital area, from pressure on the affected area.

"You would think it would be more common in big, term babies," but halo scalp injury is more common in preterm infants, Dr. Frieden said. "They may just be more susceptible to the pressure."

Providing a dermatologic consult in the NICU has its advantages and disadvantages, she noted.

The young patient has a short history, and you can do a complete exam relatively quickly. Biopsies are easy to do (if needed) because the infants are easy to hold down.

On the other hand, you go to the babies instead of patients coming to you, which involves commute time. Extra hand washing is required. Premature infants can stop breathing when touched, which can be scary for dermatologists. Rashes can be hard to see on such tiny bodies, especially when viewed through plexiglass coverings. You may have no idea what's wrong and feel inadequate. And nurses may be annoyed at your mere presence, she said.

Listen to the nurses, Dr. Frieden advised. "It is their territory. You're only a visitor."

Get permission before you do anything. Don't panic. You probably know more than you think you do, and you can get help if needed. Think in terms of disease categories if you suspect something is more than a benign iatrogenic injury.

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Look for 'Ugly Duckling' Among Acquired Nevi

SAN FRANCISCO — While scanning the acquired moles on the skin of a child or adolescent, consider whether individual moles look like they are part of a pack or if there is one that stands out—"the ugly duckling," Dr. Lawrence F. Eichenfield advised.

Mild variations in nevi are okay if several nevi look the same, but when there are many mildly atypical nevi, look for an atypically atypical lesion, Dr. Eichenfield said at a conference on women's and pediatric dermatology sponsored by Skin Disease Education Foundation.

In children, the asymmetry (A) and border irregularity (B) tend to be the most useful of the ABCDEs in identifying worrisome changes in nevi. "That makes sense because what you're looking for is uncontrolled growth—looking for one part of the mole doing something different from the other part," said Dr. Eichenfield, chief of pediatric and adolescent dermatology at the University of California, San Diego.

Remember the other ABCDEs of worrisome changes in nevi as well—color irregularity (C), diameter larger than 5 mm (D), and elevation (E).

Dysplastic nevi tend to be large (6-15 mm) with irregular borders, indistinct margins, or mixed colors (tan, brown, dark brown, and pink) instead of uniform tan or brown pigmentation.

Adolescents often develop symmetric, two-toned moles that are no cause for alarm but simply a sign of evolution.

"Just like some teenagers have some

mixed features to them—and in fact they can look a little funky—so can the moles be like that. They can have features of two types of moles at the same time," he explained.

Dysplastic nevi can be found in sun-exposed areas typical of nevi but also on the scalp, buttocks, or other sun-protected sites. A mole on the scalp may be an indication that the child eventually will develop a high number of moles (more than 50), which increases the risk for melanoma, but the scalp nevi themselves regress over time and become less worrisome, Dr. Eichenfield said.

Frequently, atypical nevi have a macular component, which gives them a pebbly or fried-egg appearance, he noted. Benign scalp nevi, too, often look like fried eggs. Finding a truly atypical nevus necessitates expert dermatopathologic review, often with multiple readers, he suggested.

Be alert for children with atypical moles and two immediate family members with a history of melanoma. Ten percent of these children will develop melanoma before age 20, and 80%-90% will develop melanoma in their lifetimes.

"If you're a pediatrician, get them to a dermatologist. If you're a dermatologist, you should probably have serial photography" for monitoring, or refer them to someone who can do this, Dr. Eichenfield said.

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DR. EICHENFIELD

Warn Mothers That Biting Babies' Nails Can Spread Herpes

SAN FRANCISCO — Mothers who bite their babies' nails instead of clipping or filing them can spread herpesvirus infection unwittingly, Dr. Meg C. Fisher warned.

Biting off infant nails "is a very common thing, particularly among Hispanic mothers or any young mothers who are afraid to use nail clippers," said Dr. Fisher, chief of pediatrics at Monmouth Medical Center, Long Branch, N.J. Advise parents who are afraid to use clippers on the nails of tiny fingers and toes to use an emery board, but not to bite, she suggested at the annual meeting of the American Academy of Pediatrics.

Herpesvirus infection is ubiquitous among adults and almost always asymptomatic. Most people infected with herpes don't know they've got the virus. Carriers shed the virus when herpes sores develop but also intermittently at times when no sores are present.

When a herpetic whitlow develops—a painful herpes infection typically on the fingers or around fingernails—it may be misdiagnosed as a bacterial infection because of the lesion's disturbingly dark coloring. "It really does look like it's gangrenous. These lesions look horrible" yet distinctive, once you're familiar with them, Dr. Fisher said. "There's nothing else that turns your finger black like that."

She described a 9-month-old patient who was treated for a week with cephalexin for presumed bacterial infection in a finger, with no improvement. The lesion was a herpetic whitlow caused by infection from her mother biting the child's nails.

Treating it with acyclovir probably doesn't make sense unless you catch the lesion early, she said. "This will get better if

you do nothing. Wait it out."

Warn parents that some herpetic whitlows recur. Treating such a lesion with acyclovir in the early phases might shorten its duration if parents bring it to your attention within the first couple of days.

"The one thing you don't want

Herpetic whitlow 'really does look like it's gangrenous. These lesions look horrible' yet distinctive, once you're familiar with them. 'There's nothing else that turns your finger black like that.'

to do is to send them to a surgeon" who will be tempted to incise and drain the lesion, thinking it's a bacterial infection, she added. That can lead to superinfection with staphylococcus or other bacteria in addition to the herpetic whitlow. Even worse, a herpetic whitlow mistaken for hand cel-

lulitis usually results in the patient being admitted to a hospital "and gets a hand surgeon or orthopedic surgeon excited," often leading to an unnecessary procedure, Dr. Fisher said. "If you can, don't admit them [to the hospital]. If you want to give IV therapy, give IV acyclovir. You don't need antibiotics."

Prophylactic therapy might make sense for patients who are prone to herpetic whitlows. Teenage wrestlers, for example, may need prophylaxis during the competitive season. Prescribing valacyclovir or famcyclovir, each of which requires fewer daily doses than acyclovir, may be the best choice to ensure compliance in these cases.

Advise athletes on herpes prophylaxis that the medication must be taken daily, and that care should be taken not to get dehydrated, which could damage the

kidneys, she said. Tell the patient that ongoing treatment could cause his or her viral isolate to develop drug resistance.

Some sports coaches can get carried away with the idea of prophylaxis, Dr. Fisher added. A summer wrestling camp in her area informed parents in early 2007 that every student should be taking acyclovir and fluconazole to avoid herpes and fungal infections.

Local pediatricians called Dr. Fisher, asking if she thought this was a good idea. "I said, 'No.' This is the kind of pressure that these elite athletes are getting," she said. The pediatricians she spoke with all refused to prescribe the drugs for uninfected athletes, and none of the students were excluded from the camp, as far as she knows.

She said she advises coaches or athletes to disinfect wrestling mats with bleach in a 1:100 dilution in water. That kills the herpesvirus and common bacteria. ■