Do You Recognize These Disorders?

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An 18-month-old girl presents with a mass in the lateral upper right orbital area (lateral brow). The lesion can be palpated beneath the eyelid just inside the lateral aspect of the orbital rim. The lesion does not appear to interfere with the girl’s vision. The extraocular movements all appear normal and, grossly, the child appears to visualize normally with her right eye. CT reveals a well-circumscribed, cystic mass without bony involvement or deep intracranial extension.

**Case 1:**
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**Dermoid cysts** are commonly noted in newborns and young infants.¹ These cysts are generally rubbery or compressible subcutaneous nodules found at the site of closure of embryonic clefts.¹ The forehead and periorbital areas are the most common sites of involvement. Orbital dermoid cysts make up 3% to 4% of all primary orbital tumors.² A series in adults suggests that the lateral canthus is a common site for orbital dermoids.³ Corneal dermoids may appear as white, elevated masses that can impede vision.⁴ Other sites of involvement include the mid chest, sacrum, perineum, and scrotum.³ Dermoid cysts are lined with epidermis and contain skin adnexal structures. Because sebaceous elements may be present, traumatic rupture of the cyst can produce intense inflammation.⁴ The lesions may extend into the periosteum and erode underlying bone.¹,³ Communication of a cyst with the CNS is possible. Dermoids overlying the sacrum may be associated with occult defects of the vertebral column or spinal cord.¹ CT or MRI of the lesion is usually indicated to demonstrate intracranial extension of the tumor. One large series of CT scans of orbital dermoid cysts in adults showed that the majority have a well-defined wall (80%) and adjacent bony changes (85%); most (86%) are not calcified. One large series in children demonstrated that only 14% of the cysts were adherent to—and 5% penetrated below—the periosteum.⁵ Surgical excision can be performed in infancy to obtain histologic confirmation of the diagnosis—and for cosmetic concerns. This child underwent an uneventful surgical procedure and had excellent scar camouflage following eyelid crease incision.⁵ Endoscopic excision can also be performed with good cosmetic outcome.⁶

**REFERENCES:**
1. Cohen BA. Pediatric Dermatology. 2nd ed. Philadelphia:

**Case 2:**
Numerous small (about 2-mm) pustules were noted on the face, neck, trunk, and extremities of this 3-day-old African American boy. A few hyperpigmented macules were also noted immediately following delivery. The pustular lesions lacked an erythematous base. The child was vigorous and afebrile; he was eating well and otherwise appeared healthy. Central crusting developed over the pustular lesions during the week after the child was discharged from the newborn nursery. Following desquamation of the crust, a hyperpigmented macule was noted to persist following healing at many of the lesion sites. Are you familiar with this condition? What are the chief diagnostic considerations? **Case 2:** This child has **transient neonatal pustular melanosis.** The disorder affects approximately 4% of all newborns.¹ Up to 5% of African American infants are affected, as are...
0.1% to 1% of all white newborns. Unlike erythema toxicum neonatorum, transient neonatal pustular melanosis generally appears at birth; in many affected children, it develops prenatally. Sites of predilection are the anterior neck, forehead, and lower back, although any part of the body may be affected. The rash often appears at different stages of evolution. It commonly manifests as 2- to 3-mm hyperpigmented vesicular and pustular lesions that can involve almost any area of skin. A characteristic collarette of scale may be noted on close examination of the area surrounding the lesion. Vesicles develop into pustules that rupture, leaving hyperpigmented macules that resolve spontaneously within 3 months. If the vesiculopustular stage occurs entirely in utero, only the final macular stage may be visible during the newborn period. A Wright stain performed on a smear of the pustules reveals numerous neutrophils. It is especially important to make the correct diagnosis of pustular skin disorders in the neonate. Pustules can be a manifestation of sepsis, congenital disseminated candidiasis or herpes, or other serious infectious diseases. Other noninfectious conditions in the differential include erythema toxicum neonatorum, infantile acropustulosis (especially in African American infants), Langerhans cell histiocytosis, and neonatal eosinophilic pustular folliculitis. Transient neonatal pustular melanosis is a self-limited disease that requires no treatment. REFERENCES:


Case 3: Nevus sebaceous, or organoid nevus, is a common, benign neoplasm that is present at birth and usually found within the first few months of life. Also referred to as the nevus sebaceous of Jadassohn, the lesion is found in 0.3% of newborns. Occasionally, nevus sebaceous can present as grouped papules with a linear or swirled pattern. Most lesions are not associated with internal organ abnormalities. Widespread lesions (extending over a large portion of the body surface) infrequently have been associated with an epidermal nevus syndrome typified by ectodermal defects in the eye and brain, producing ocular problems, mental retardation, and convulsions. Three clinical stages have been identified for nevus sebaceous. From infancy through puberty, lesions appear as sharply demarcated, round to oval, linear to crescent, yellow to orange hairless plaques on the scalp, face, or neck. The second stage appears at puberty, with the development of a dark, irregular, oily, roughened surface. The skin structures present within a nevus sebaceous become overdeveloped with the hormonal (androgen) influence at puberty. The third stage is characterized by the development of benign or malignant neoplasm within the lesion. Most neoplasms that develop within a nevus sebaceous are benign. However, neoplastic transformation occurs in 10% to 30% of nevus sebaceous lesions. The most common tumor is a low-grade basal cell carcinoma that is found in 7% to 14% of cases. Other malignancies include squamous cell, sebaceous gland, and apocrine carcinomas. These tumors tend to appear in the fourth to sixth decades of life (median, sixth decade). The potential for malignant transformation and cosmetic considerations lead many practitioners to recommend complete surgical removal by puberty. Childhood removal may provide the opportunity for good cosmetic outcomes, but uniform agreement about prophylactic surgery is lacking. Some practitioners prefer to recommend surgery only when local change suggests the presence of a tumor. REFERENCES:


Case 4: This 4-day-old is noted to have blistering on the lips. The child is breastfeeding. What is this finding? Case 4: Some callus-like areas can be found on the lips, especially in breast-feeding infants. The center of the upper lip is the most common site. These lesions have been called suckling blisters or sucking blisters. They may vanish between feedings. These blisters do not require any
treatment. They gradually disappear as the lip toughens.

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