Kodachromes from inpatient consults

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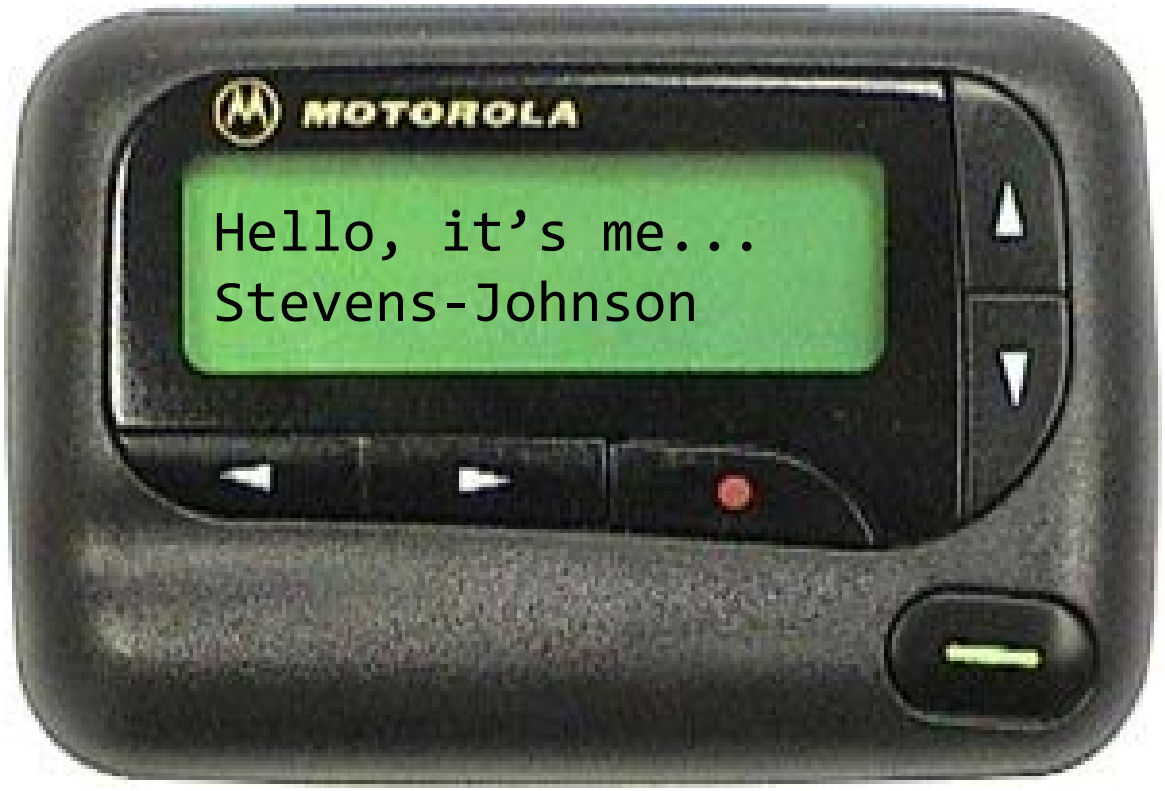
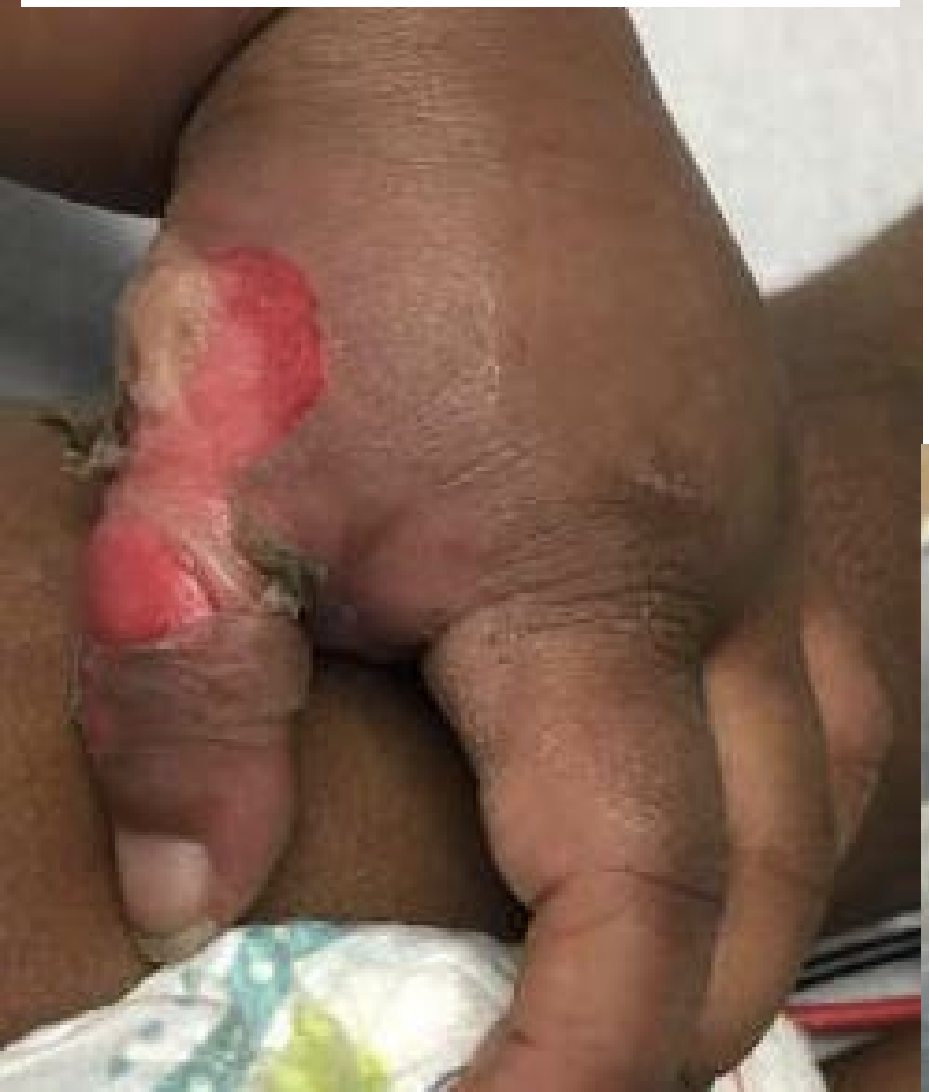
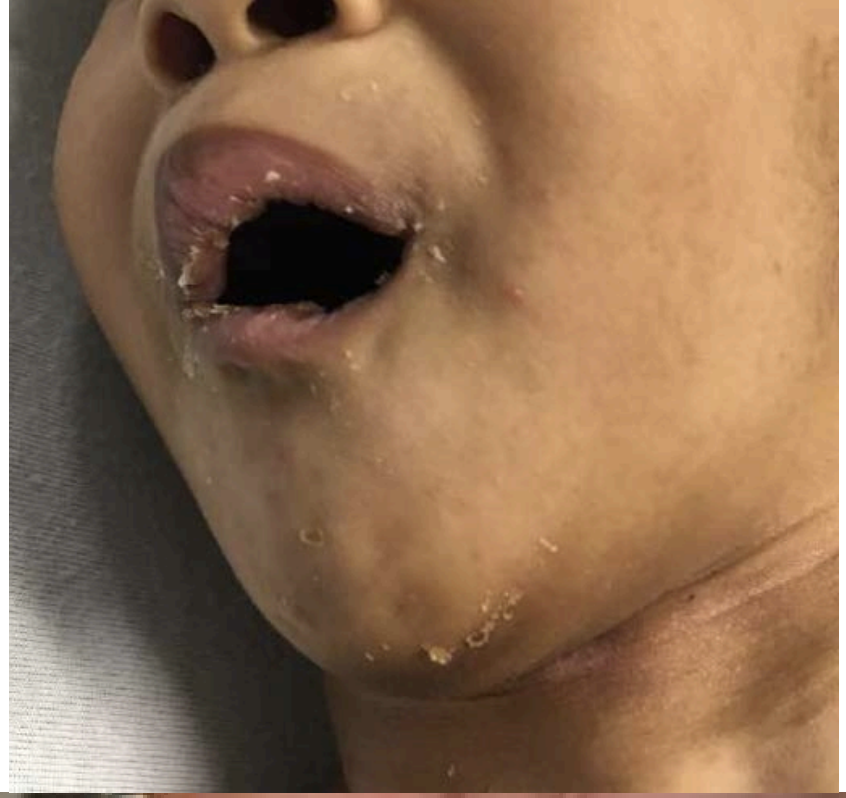
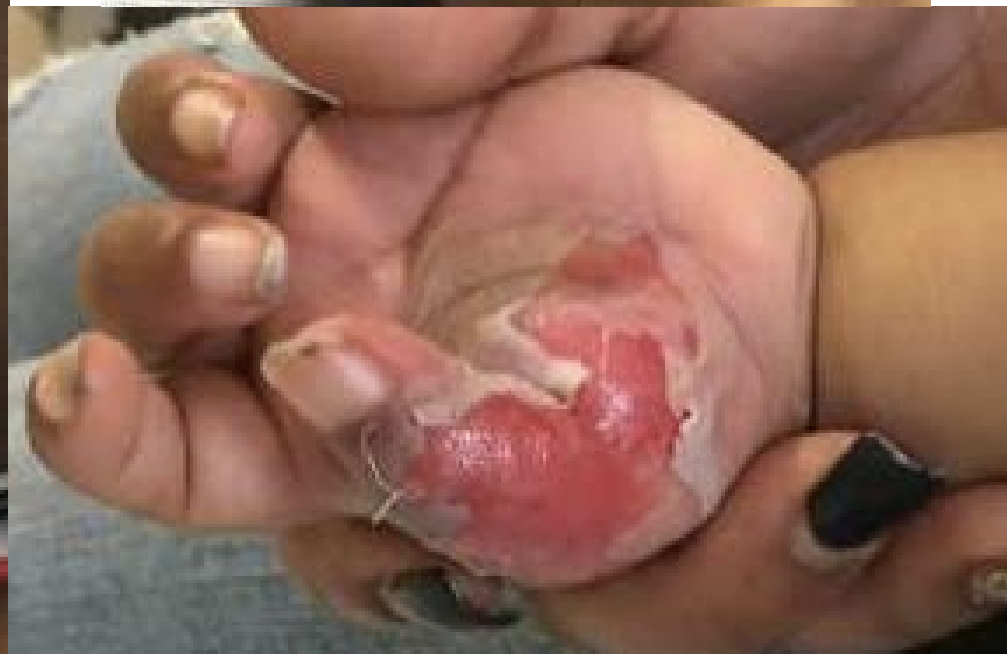
April 7, 2017

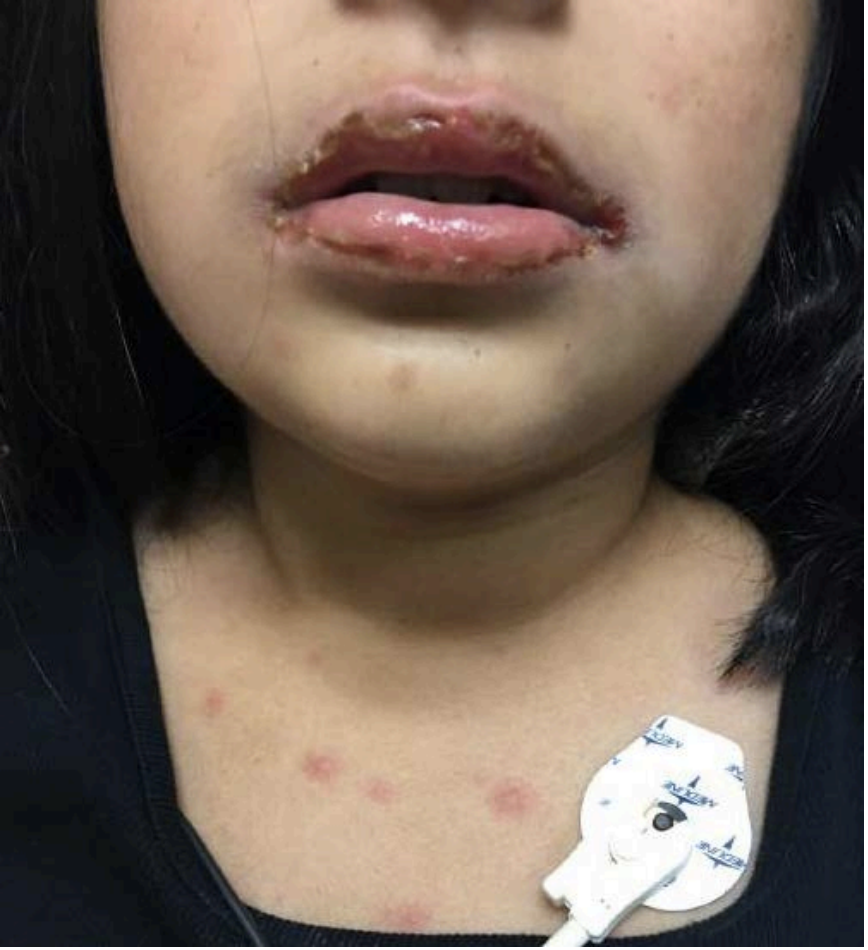

MOTOROLA
Hello, it’s me...
Stevens-Johnson

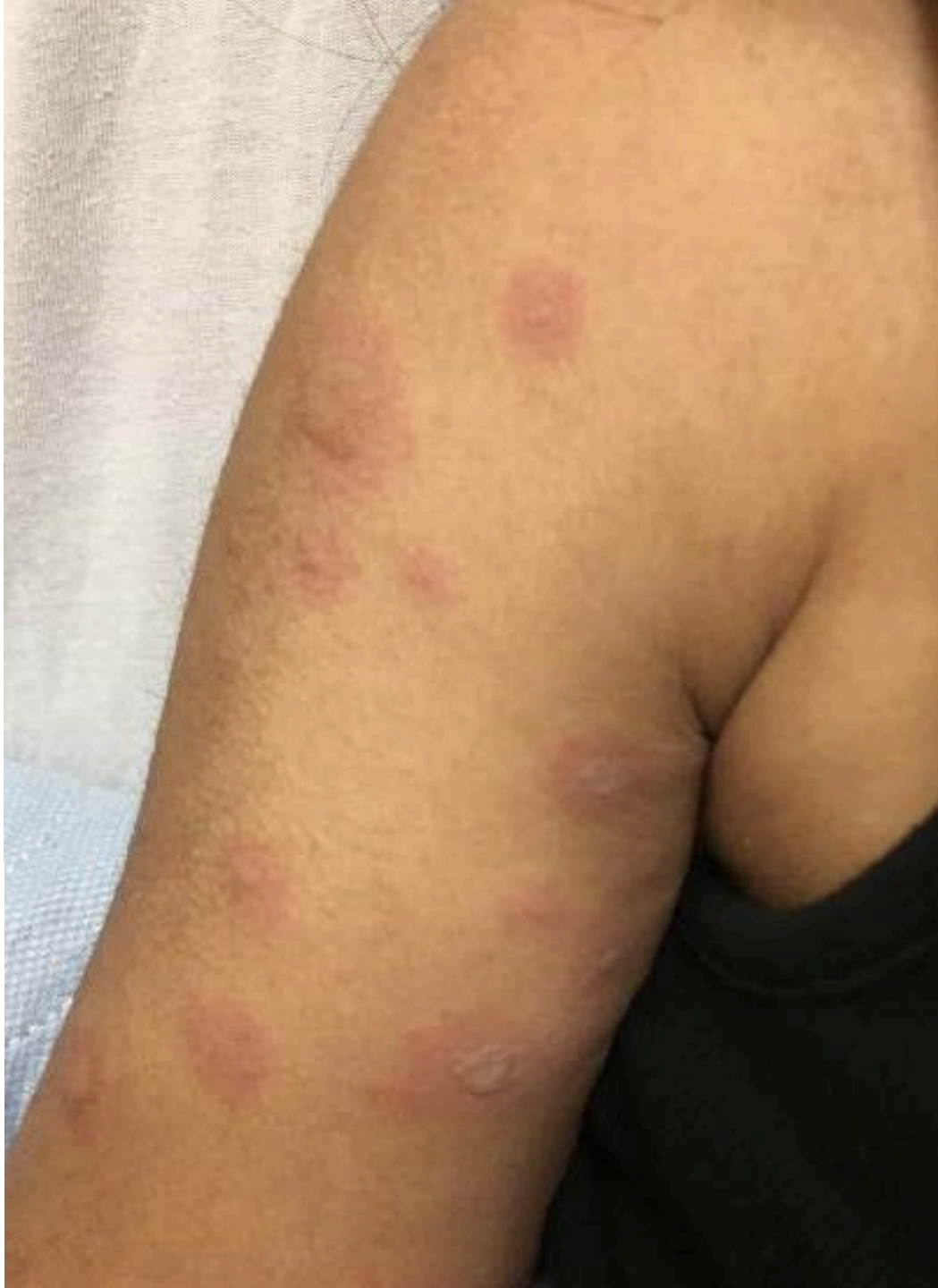
- HIE, spasticity, G-tube
- Clindamycin for pneumonia 10 days ago
- Levetiracetam home med



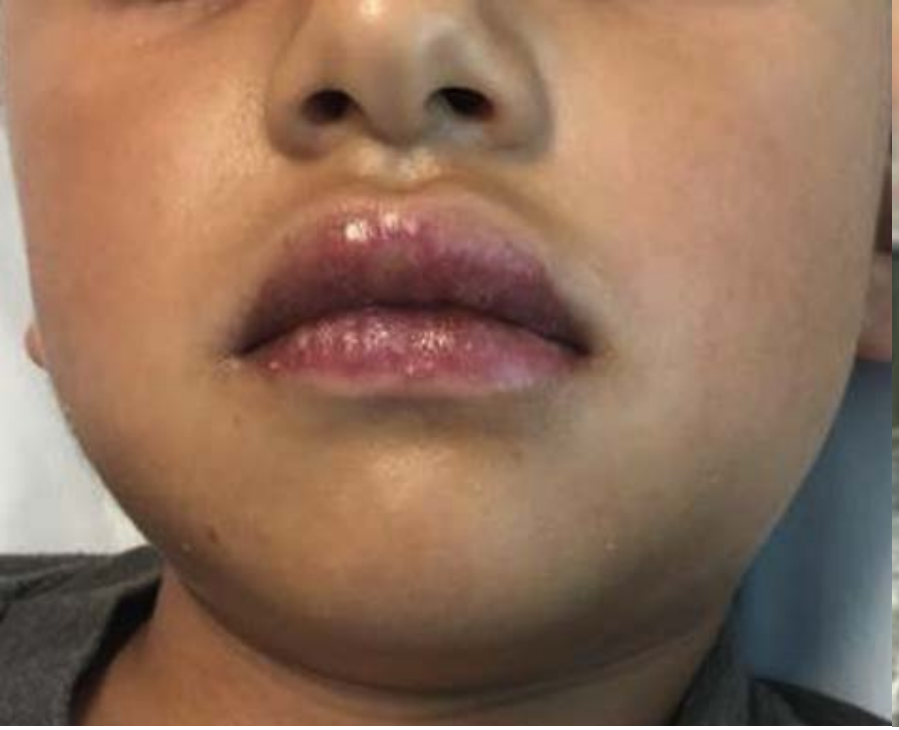




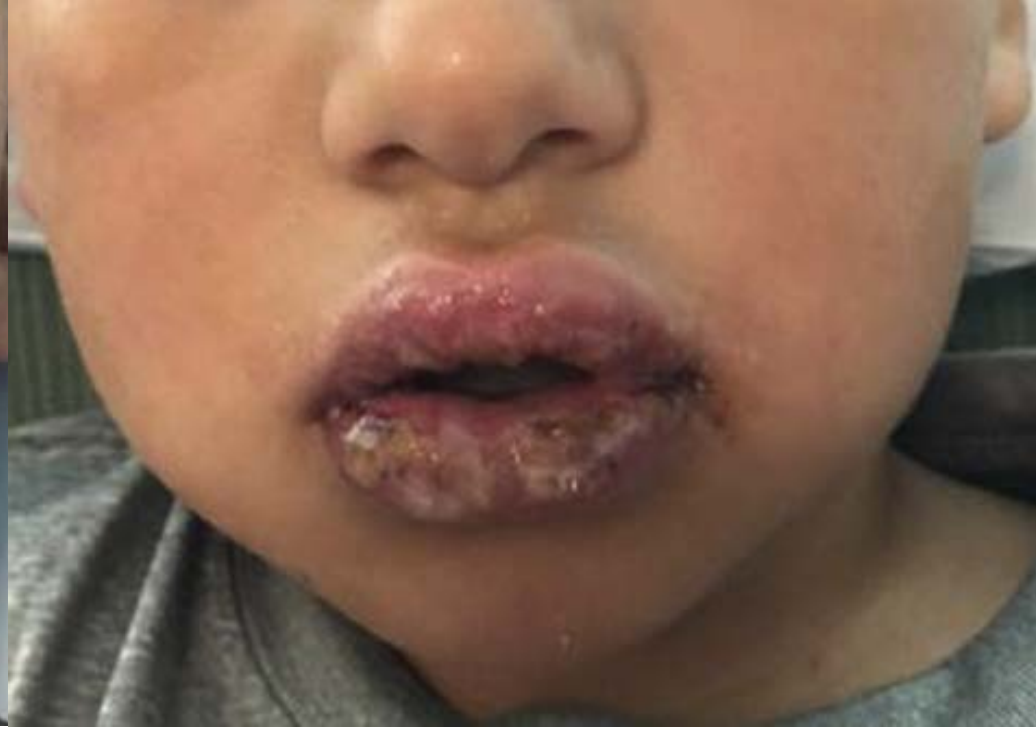




- Fever and cough 10 days ago
- Acetaminophen, dextromethorphan
- Discomfort with urination



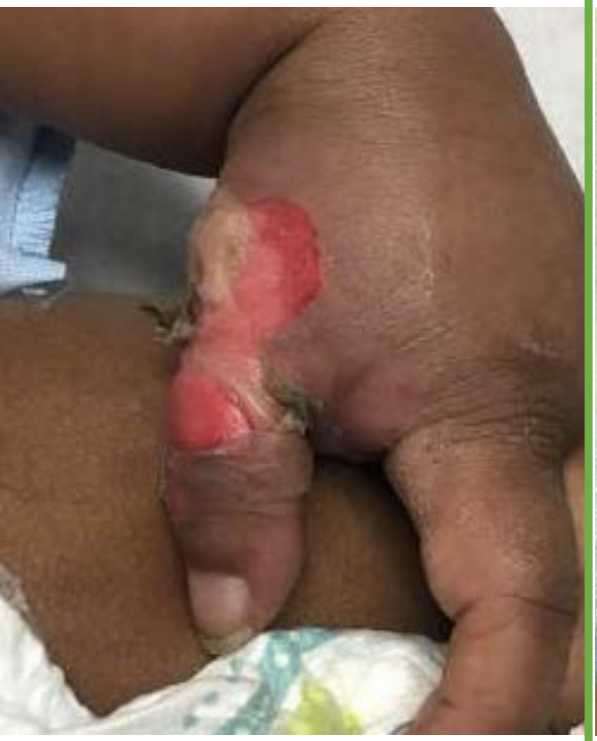
Day 1



Day 3

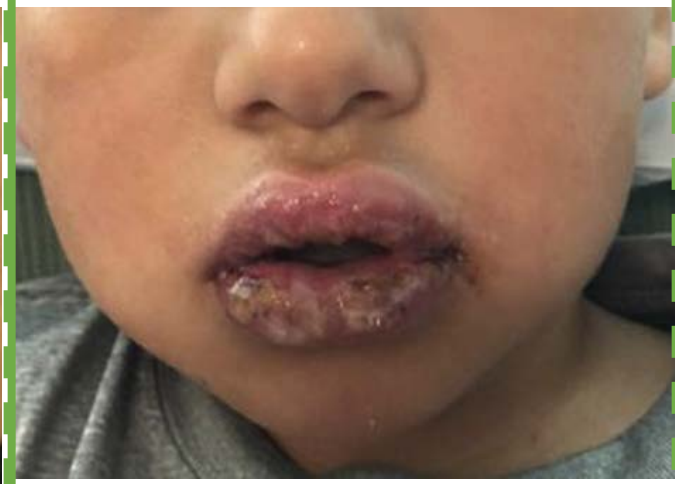
- Cough, rhinorrhea for 14 days
- Eyelid swelling
- No skin rashes or blisters
- No other mucosal sites
- No meds

Who has Stevens-Johnson?



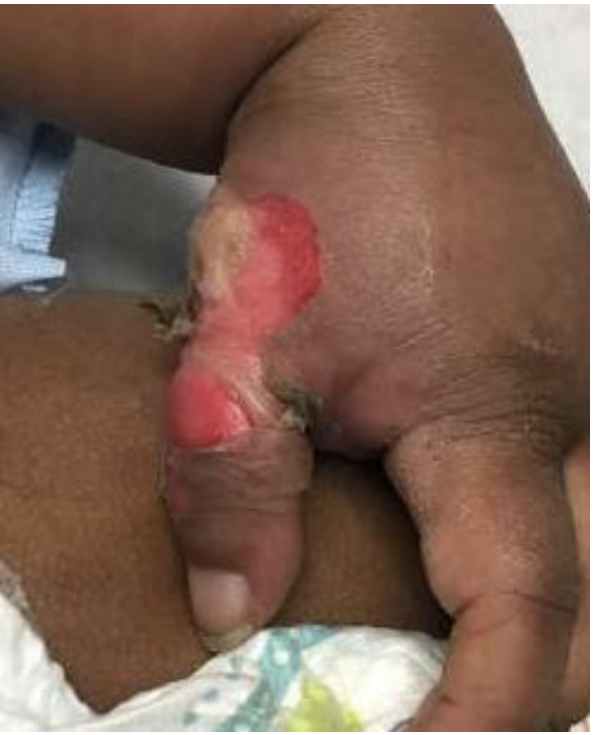
A

B



C

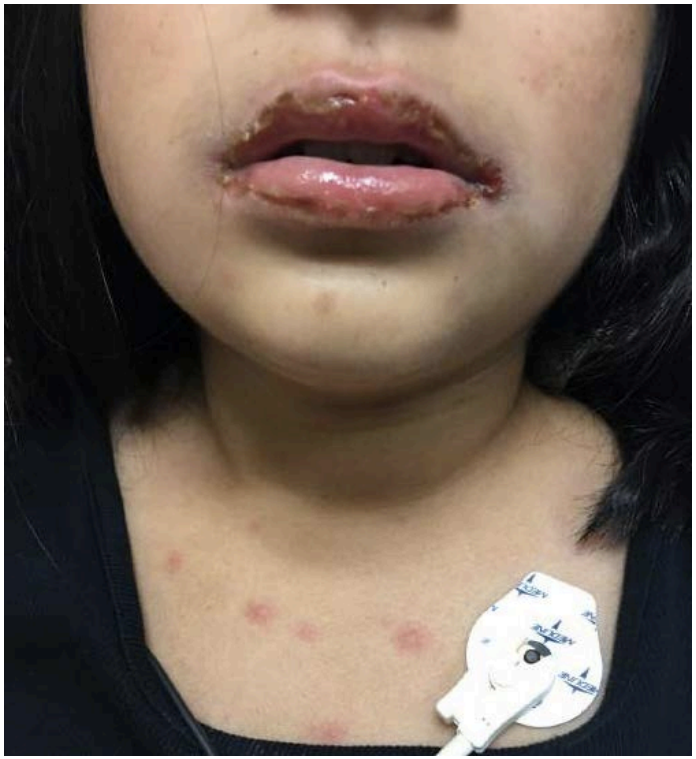
Burn (thermal vs. chemical)

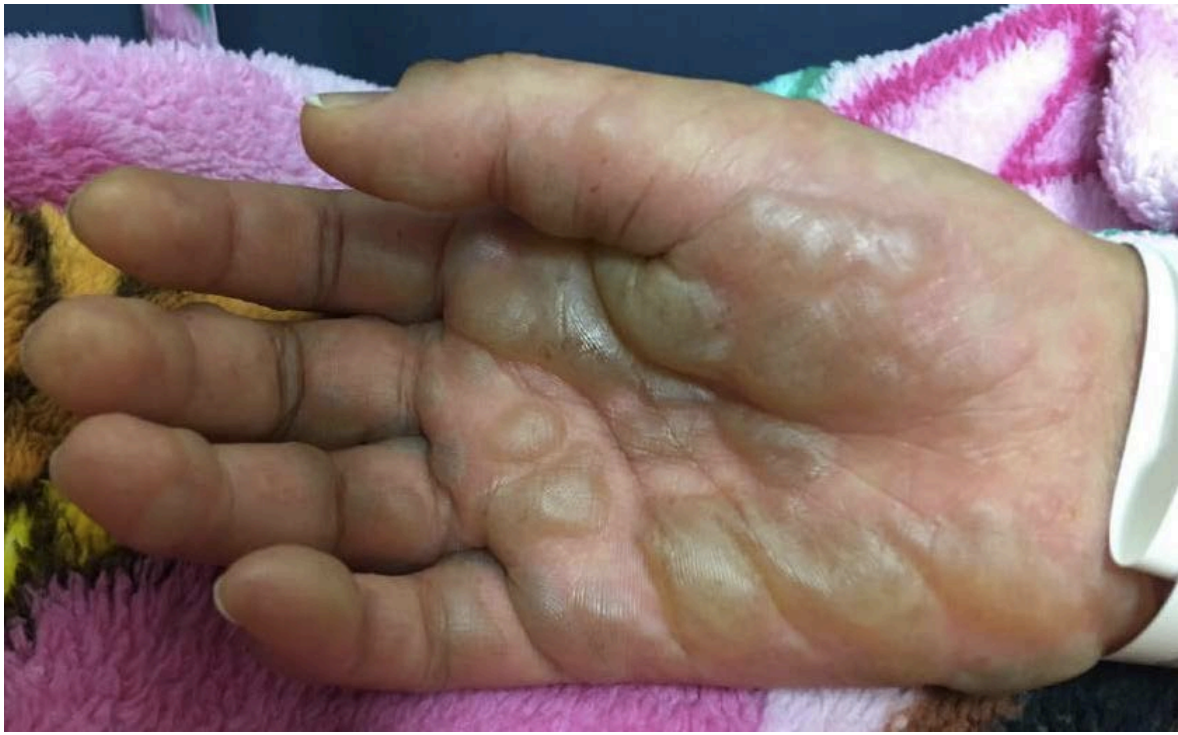


A

- Very localized
- Varying thickness of blistering
- No mucosal involvement
- Clindamycin unlikely
  - More common: sulfa antibiotics
- Levetiracetam unlikely
  - More common: other anticonvulsants

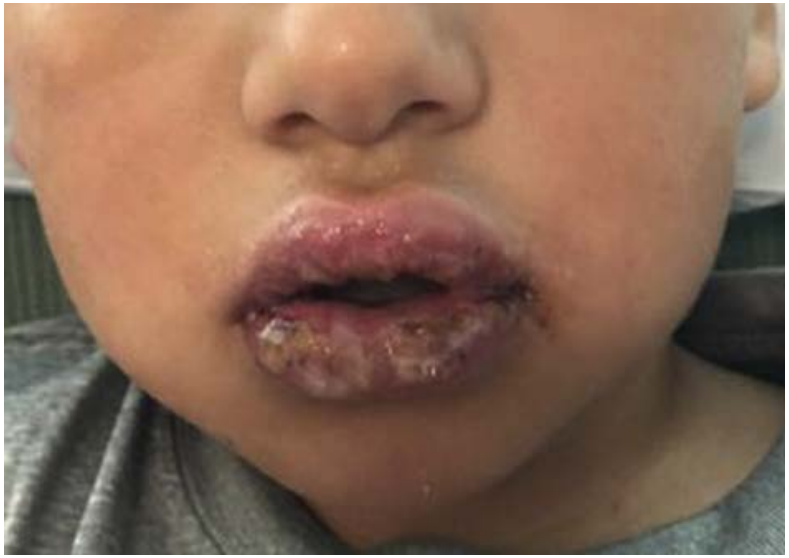
Stevens-Johnson syndrome

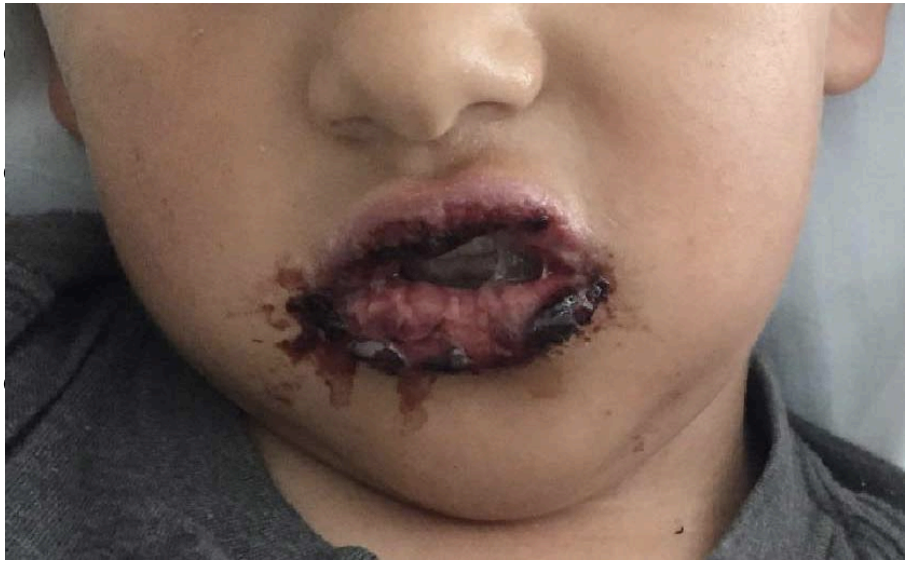




B

Stevens-Johnson spectrum

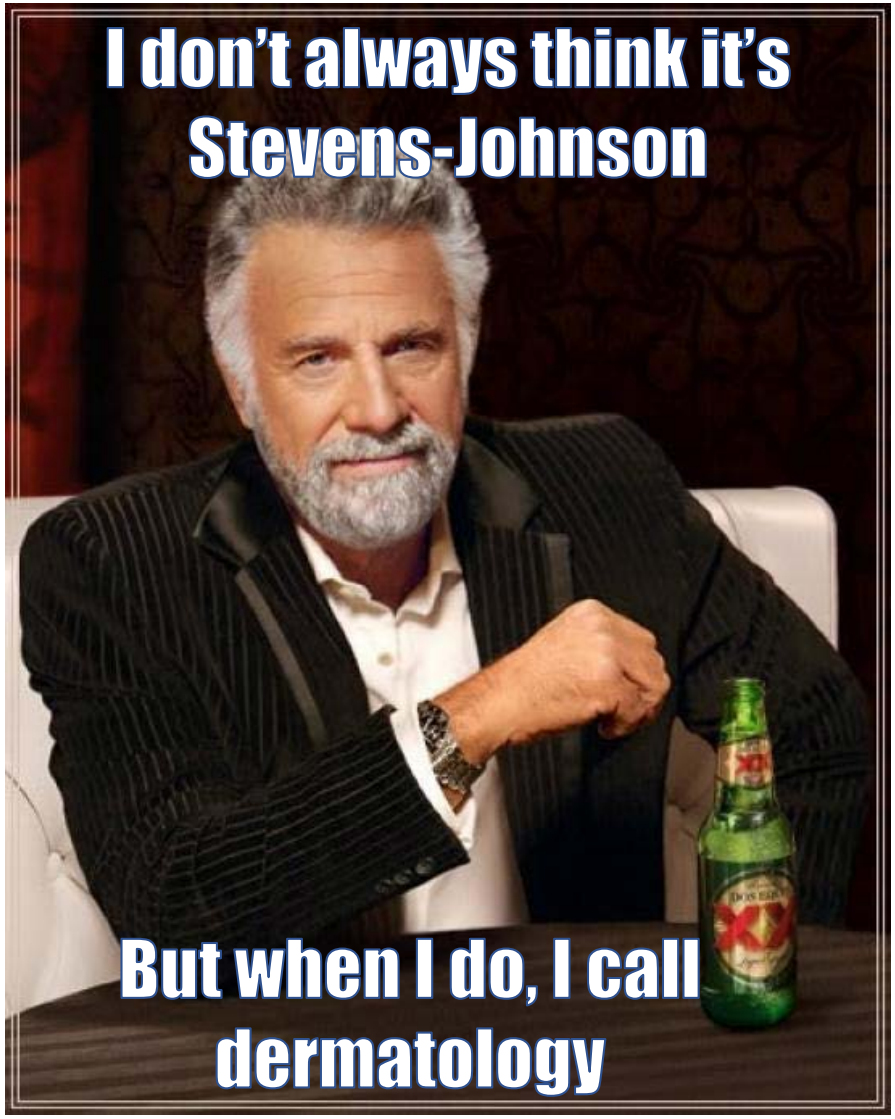




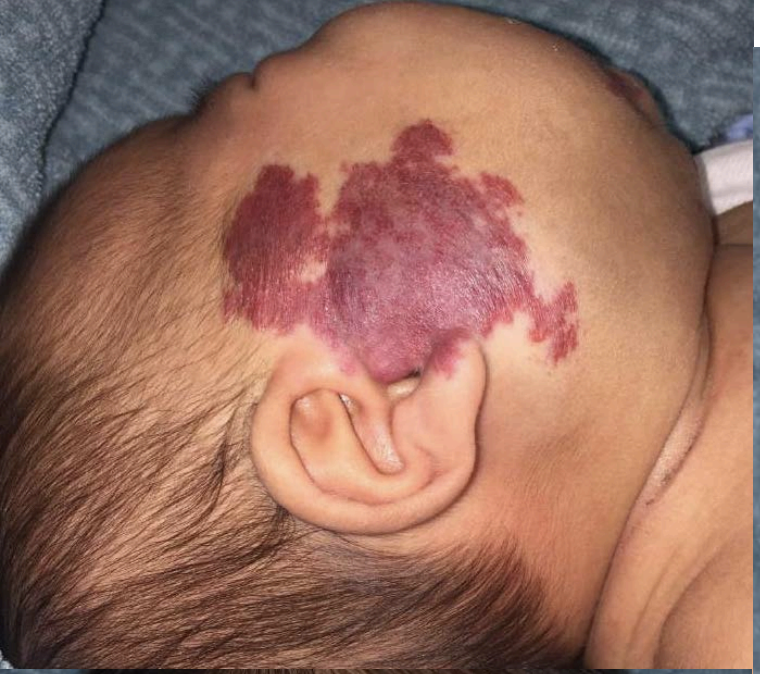
C

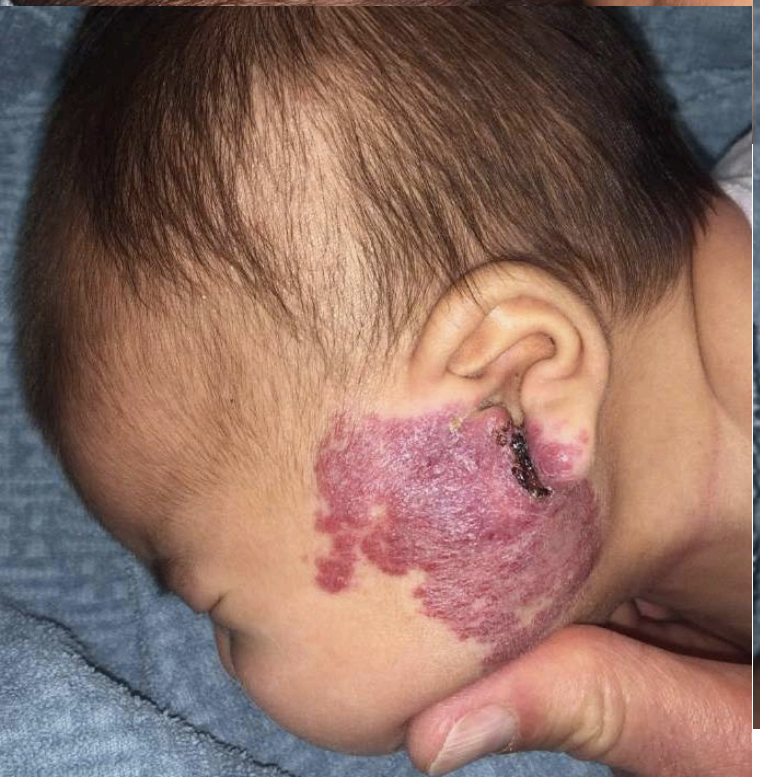
Day 3

Day 6


I don't always think it's Stevens-Johnson
But when I do, I call dermatology


MOTOROLA
Not your mama’s
hemangiomas





- Lesions present since birth, growing
- Ulcerated at left preauricular area
- Stridorous noises when crying

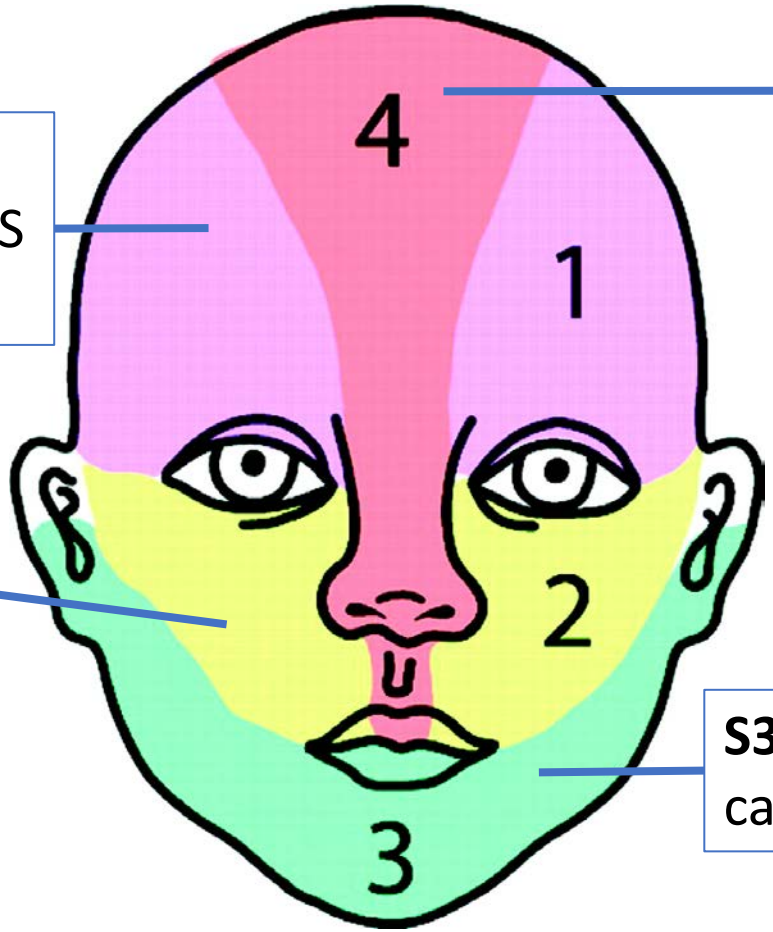
What to do first?

- A) Check vitals and start propranolol
- B) MRI/MRA, echo, ophtho consult, ENT consult
- C) Start systemic steroids
- D) Biopsy and stain for GLUT-1 to confirm diagnosis

Segmental hemangioma(s)

- Concern for PHACE syndrome
  - Multidisciplinary workup
  - Typically done as inpatient at Rady's
- **Do not start propranolol until workup complete**
  - Risk of stroke if high-risk cerebrovascular anomaly
- Biopsy generally not indicated

Segmental facial hemangioma with PHACE syndrome



S1: highest risk for PHACE, more likely CNS involvement

S2: less likely PHACE

S4: ¯_(ツ)_/¯

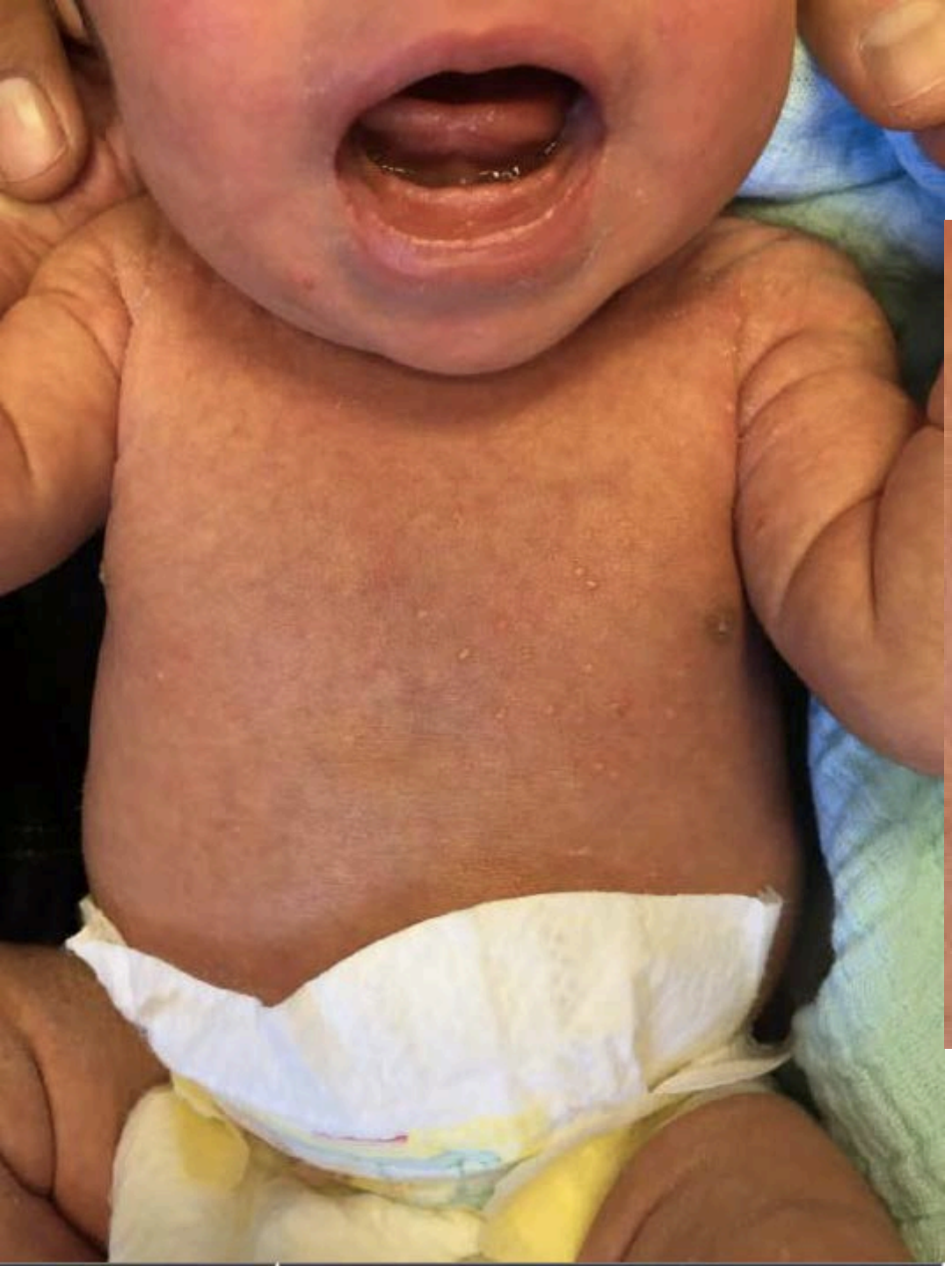
S3: subglottic/laryngeal, cardiac involvement

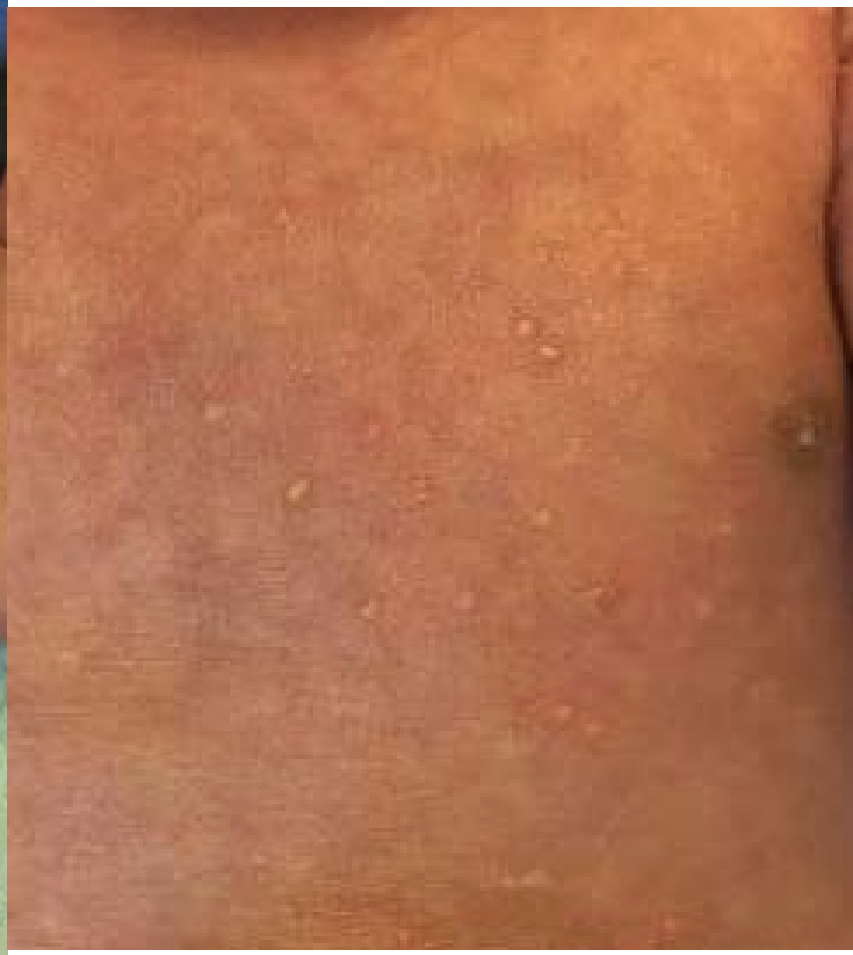
Haggstrom, et al. *Pediatrics* 2010

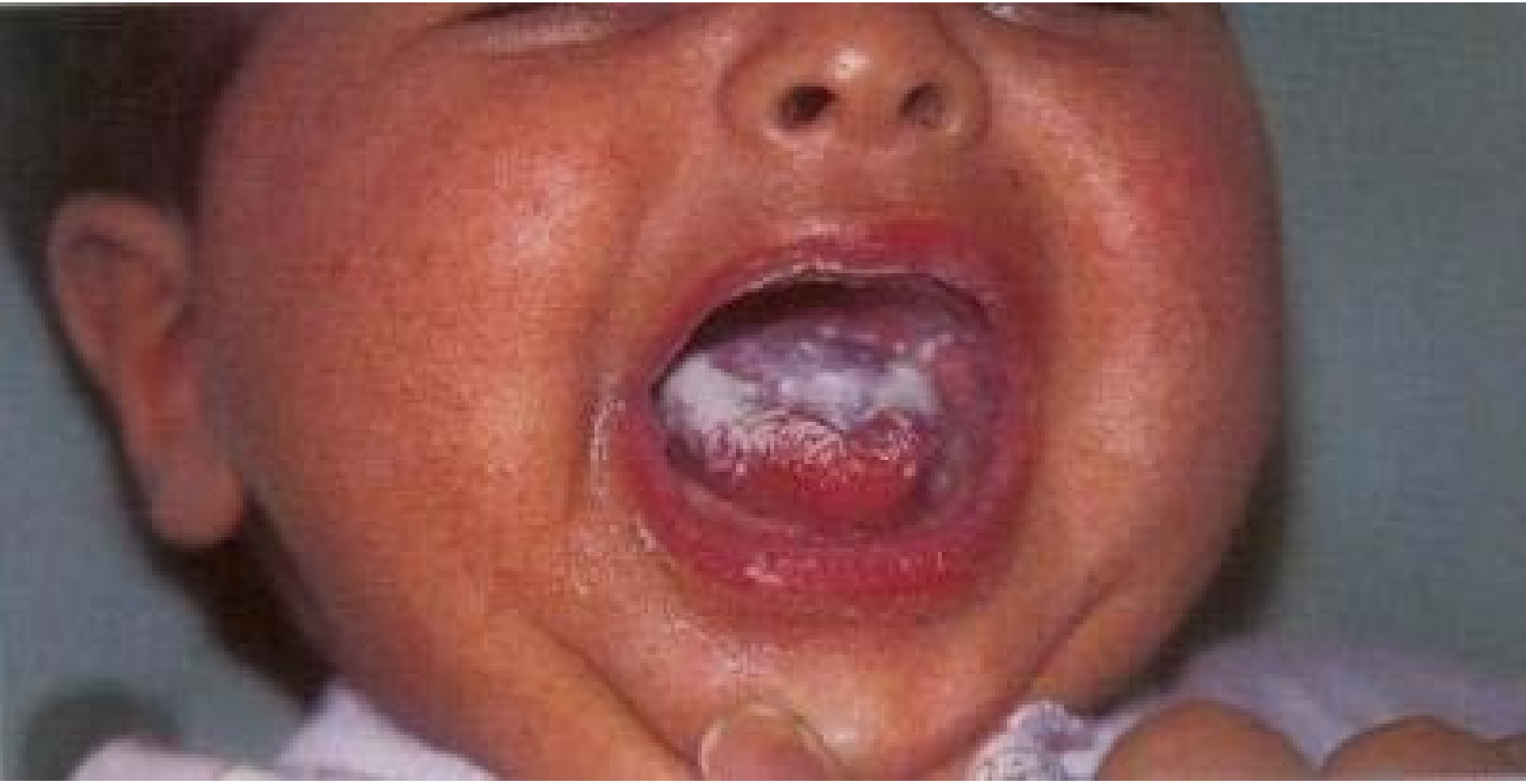
Case

History

- 10 day old F with scattered pustules
- Started at day 3, still getting new ones
- Bacterial culture by PCP negative but showing “yeast growth”
- Clinically stable
- Born post-term by vaginal delivery







Congenital candidiasis

- Relatively rare (100 cases)
- **Potentially serious** if preterm or low birthweight
- Associated with maternal yeast infection, perinatal instrumentation, antibiotic ppx?
- Can happen in vaginal **or** C-section delivery

DDx

- Eosinophilic pustular folliculitis
- Erythema toxicum neonatorum
- Transient neonatal pustular melanosis
- Incontinentia pigmentii
- Varicella

Treatment

- If asymptomatic:
  - Monitor or treat with topical antifungal
- If high risk or not clinically stable:
  - Admit for workup, including CXR, LP
  - Amphotericin B or fluconazole

Key points: SJS

- Consider other causes of blistering or cheilitis
  - Unilateral involvement is unlikely to be SJS
  - Look for new medication started 1-3 weeks ago
- Severe mucositis from infection should be treated as SJS

Key points: hemangiomas

- Segmental lesions warrant multidisciplinary workup for PHACE syndrome
- Hold off on propranolol until workup complete
- Mandibular lesions risk airway involvement

Key points: congenital candidiasis

- Rare, but in DDx of more common neonatal pustular eruptions
- Can be serious in preterm infants

Thank you