



# IADVL

## SIG Pediatric Dermatology (IADVL Academy)

Issue No.5, June 2019

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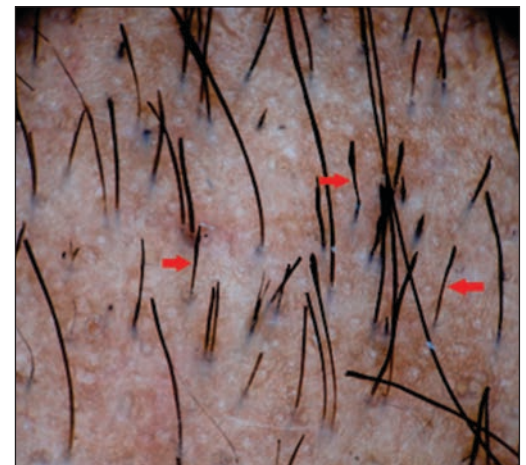
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## Dermoscopy in pediatric age group

Dr. Samipa S. Mukherjee

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A dermoscope (dermatoscope) is a non-invasive, diagnostic tool which visualizes subtle clinical patterns of skin lesions and subsurface skin structures not normally visible to the naked eye. It has also been called a skin surface microscope, epiluminescence microscope or episcopes.

The basic principle of dermoscopy is transillumination of a lesion and studying it with a high magnification to visualize subtle features.

### Why dermoscopy in pediatric age group?

- Office procedure
- Non invasive
- Zero downtime
- Helps in convincing the parents
- Easy to observe and decipher as opposed to HPE
- Can help in treatment monitoring
- Adjunctive tool where biopsy cannot be performed

### Constraints of doing histopathological examination in pediatric age group:

- Dealing with anxiety of patients and parents
- Downtime
- Invasive procedure
- Restraining the patient while procedure
- Anesthesia risks
- Deciphering and decoding histopathological findings to the curious parents is a humungous task

### Clinical scenarios where dermoscopy can be of use:

#### 1. Patchy hair loss

To differentiate between conditions like trichotillomania, alopecia areata and congenital triangular alopecia.



**Figure 1.** Alopecia areata showing black dots and exclamation mark hair



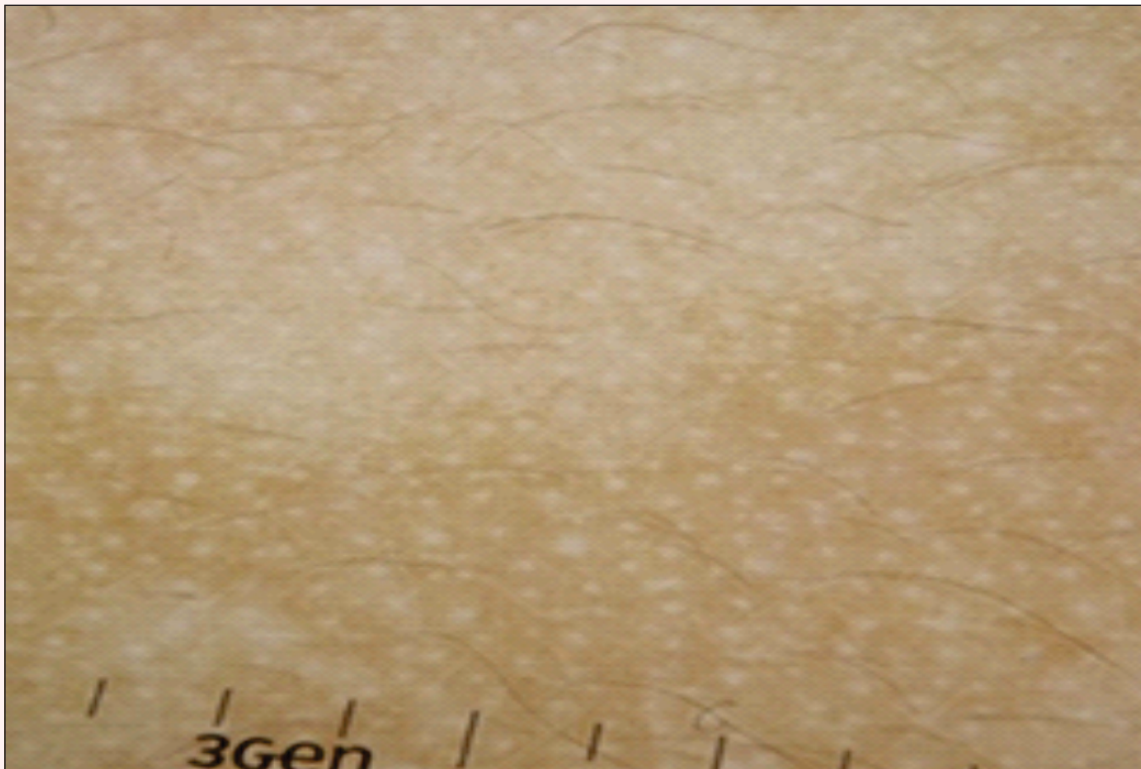
**Figure 2.** Trichotillomania showing black dots, broken hair, flame hair, burnt matchstick sign



**Figure 3.** Congenital triangular alopecia showing “carpet of vellus hair”

**2. Hypopigmented lesions in pediatric age group**

To differentiate between conditions like nevus depigmentosus, vitiligo and ash leaf spot



**Figure 4.** Nevus depigmentosus showing hypopigmented macule with uniform faint reticular pigment network.

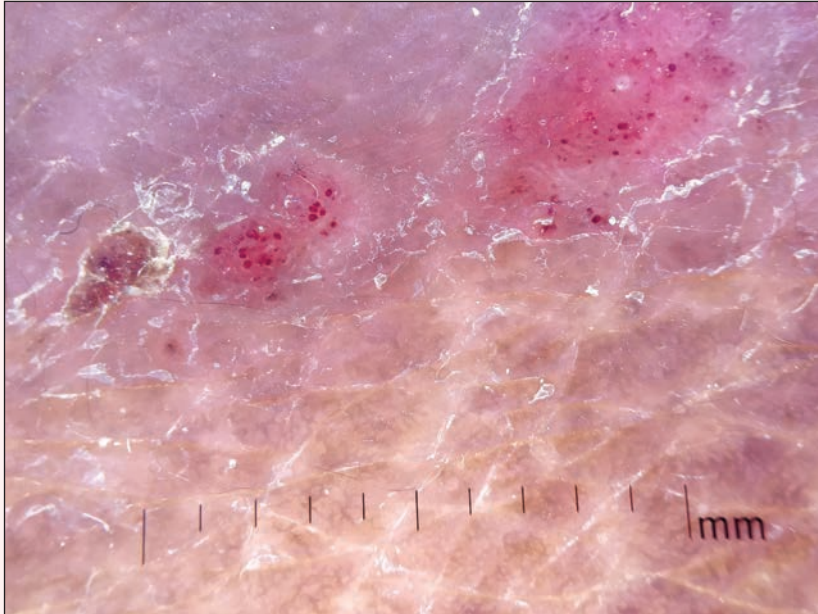


**Figure 5** Vitiligo showing blanched white areas devoid of any pigment network



**Figure 6** Ash leaf macule showing the co existence of areas with faint reticular pigment network and areas devoid of pigment network.

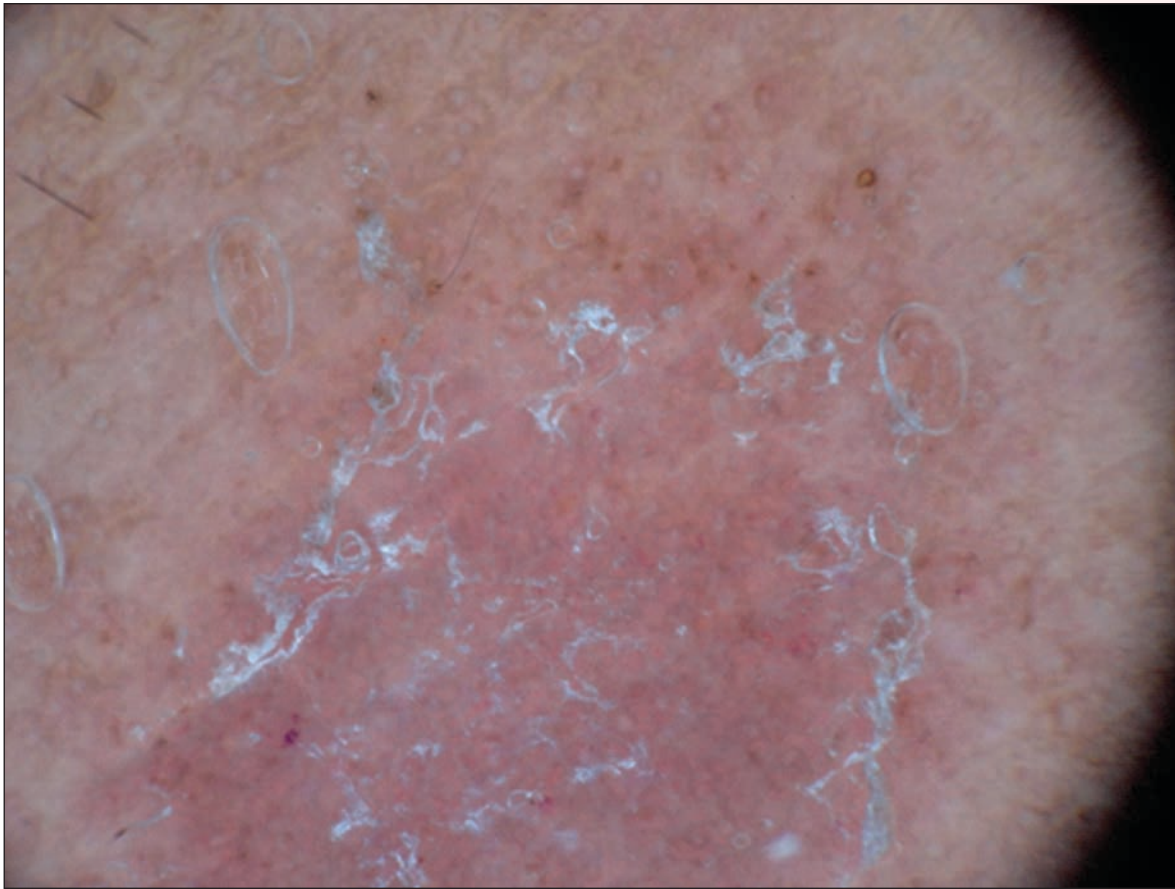
3. To differentiate clinical conditions presenting with a scaly red plaque like discoid eczema, psoriasis and pityriasis rosea.



**Figure 7.** Discoid eczema showing uneven distribution of red dots and yellow clods.



**Figure 8** psoriasis showing sheets of uniformly distributed red dots and globules



**Figure 9** Pityriasis rosea showing bizarre scales and multicomponent blood vessels

**What are the limitations of dermoscopy?**

- Limited studies and lack of specific features in conditions like Systemic Lupus Erythematosus, leprosy, cutaneous lymphomas etc
- In the court of law its validity as a test is questionable
- Objective errors
- Viewer to viewer variation
- Training in the field needed
- Placing the dermoscope and capturing an image in an irritable child may be difficult

Thus to conclude dermoscopy reduces the need for biopsy in common clinical case scenarios and studies show it increases the clinical examination time by only 72 seconds!

Clinico dermoscopic histopathological correlation is the most reliable.

Histopathological evaluation should be definitely resorted to in cases where dermoscopic features are non specific or requires long duration treatment or where we may need immunosuppressives. Dermoscope is not a wonder tool but it definitely proves to be a third eye to the dermatologist.

# Clinical scenarios (vascular lesions)

Dr Resham Vasani

## 1. Clinical Scenario

An infant is brought by parents /referred by pediatrician with (PWS) port wine stain on face

### The clinical Problem

1. When does one suspect Sturge weber syndrome in an infant with PWS on face?
2. Should presymptomatic MRI be done to rule out (Sturge Weber Syndrome) SWS? If yes, when?
3. Does a presymptomatic MRI improve the neuroectodermal outcome?

### Reference Article

Zallmann M, Leventer R, Mackay M, Ditchfield M, Bekhor P, Su J. Screening for Sturge-Weber syndrome: A state-of-the-art review. *Pediatric Dermatology*. 2017;35(1):30-42.

### What this article does

Examines evidence in favour of screening for SWS based on effect on Neurodevelopmental outcomes against risk and benefits of MRI and EEG.

Below mentioned are few answers that have been clarified by the article.

### Which infants to screen for PWS?

Forehead region involvement is the strongest predictor of SWS  
Hemifacial and Forehead PWS are at highest risk of PWS

### Should presymptomatic MRI be done?

No evidence that presymptomatic MRI, which is an otherwise expensive procedure improves neurodevelopmental outcomes. We do not know what is the optimal timing and the sensitivity of MRI The reasons are - Sensitivity of MRI is lowest below the age of 6- 12 months. The findings are isolated, non specific, and can be easily missed. Experienced neuroradiologists are required. Hence an early negative scan cannot exclude SWS and it is difficult to provide conclusive answers to the parents. Conversely, in older children ,a screening MRI will have a diminished value because most patients will have demonstrated symptoms by that time and it counteracts the potential improvement in detection.

The diagnostic utility of an early EEG in presymptomatic SWS is possible but is not established.

### Take home message

Allaying anxiety about diagnostic uncertainty is not achieved through a scan but through detailed education , appropriate clinical monitoring and nuanced reassurance.

## 2. Clinical Scenario

3 month old child is brought by the parents presenting with an infantile hemangioma in the left periocular area, not obstructing vision currently

### The clinical problem

What are the clinical predictors that indicate that the child with periocular hemangiomas should be urgently referred to an ophthalmologist?

### Reference article

Samuelov L, Kinori M, Rychlik K, Konanur M, Chamlin S, Rahmani B et al. Risk factors for ocular complications in periocular infantile hemangiomas. *Pediatric Dermatology*. 2018;

### What this article does?

The article attempts to characterize clinical features of periocular infantile hemangiomas that predict negative ocular outcomes and thus require prompt referral to an ophthalmologist.

### Below mentioned is the answer to the clinical problem provided by the article-

Predictive factors for ocular complications in patient with periocular infantile hemangiomas are –

1. Diameter greater than 1 cm
2. Deep component
3. Upper eyelid involvement

These patients should be promptly referred to an ophthalmologist and treatment should be strongly considered.

## Commentary on publications

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Hyderabad

### Publication 1

Folster-Holst R, Kreth HW. Viral exanthems in childhood. Part 3: Parainfectious exanthems and those associated with virus-drug interactions. *J German Soc Dermatol* 2009; 7; 506-510.

#### Commentary:

Viruses cause not only direct infectious exanthems, but also parainfectious exanthems, which provoke skin alterations via interactions with the immune system. These distinct exanthems, for instance Gianotti-Crosti syndrome, pityriasis rosea and pityriasis lichenoides group, do not reflect a specific pathogen but can occur in the course of many viral infections. In addition, some exanthems result from the interaction between viruses and drugs (Infectious mononucleosis).

So differentiation of Viral Exanthems from Paraviral Exanthems is necessary in view of clinical manifestations, isolation, treatment, complications and prognosis.

#### Infectious exanthems:

1. Acute
2. Infectious so isolation is needed
3. Single virus is the causative agent
5. Classical prodromal phase is present with or without exanthems
6. Skin rash (exanthems) is due to minor viremia (Involvement of other systems are due to major viremia)
7. Virus or its particles can be isolated for the diagnosis
8. Specific antiviral therapy may be indicated depending on age, immune status and severity of the disease
9. May be responsible for secondary complications like pneumonia, otitis media, blindness, encephalitis etc.
10. Examples include Measles, Varicella, German measles etc.

#### Parainfectious exanthems (distinct exanthems or Paraviral exanthems):

1. Sub acute to chronic
2. Infectiousness is very low so isolation is not needed
3. Multiple groups of viruses are the causative agents
5. Classical prodromal phase is not seen
6. Skin rash (exanthems) is due to interactions with the host immune system.
7. Virus or its particles cannot be isolated
8. Specific antiviral therapy is not indicated
9. May not be responsible for secondary complications
10. Examples include Gianotti-Crosti syndrome, pityriasis rosea, pityriasis lichenoides group etc.

### Publication 2

Katakam BK, Kiran G, Kumar U. A prospective study of herpes zoster in children. *Indian J Dermatol* 2016; 61(5);534-539.

#### Commentary:

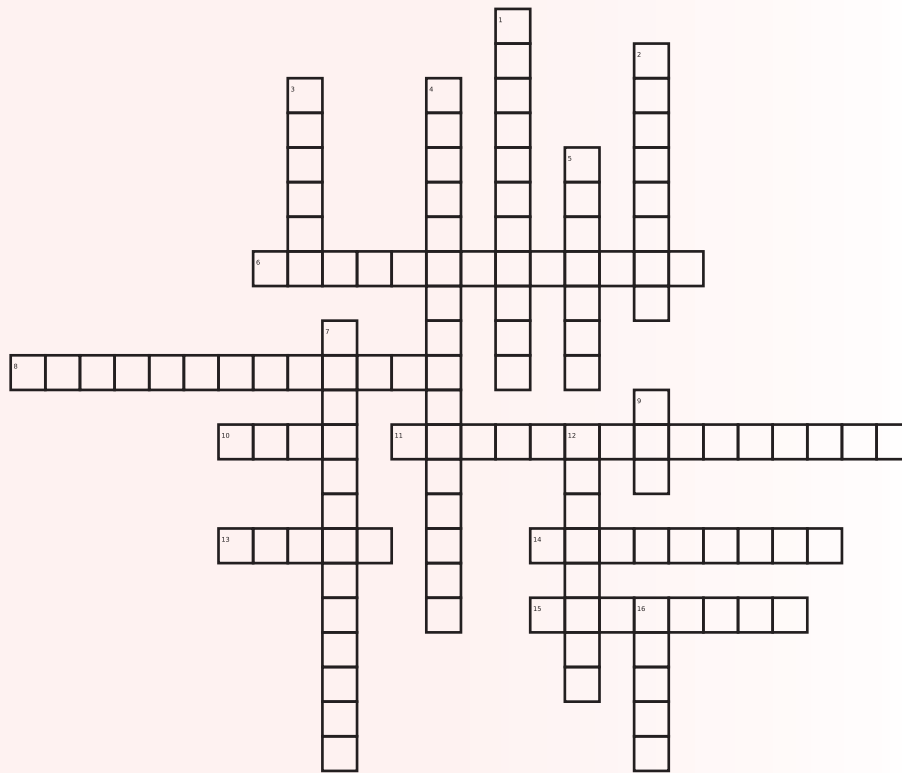
Herpes zoster in children may imply immunodeficiency. Institution of antiviral therapy depends on the age and immune status of the child. The prognosis is generally good both in healthy and in HIV-reactive children with CD 4 count above 350/cumm. Appearance of herpes zoster in children does not always imply an underlying immunodeficiency or malignancy. Herpes zoster, though uncommon in children, needs high index of suspicion and should be considered in the differential diagnosis of vesicular eruptions.

Treatment options are based on the patient's age, immune status, duration of symptoms, and presentation. Several studies indicate that antiviral medications decreased the duration of symptoms and the likelihood of post herpetic neuralgia, especially when initiated within 3 days of the onset of rash. In children between the age group of 2 and 12 years, who are otherwise healthy, oral acyclovir need not be prescribed. An important study by Kubeyinje suggested that the use of acyclovir in healthy young children with zoster is not clearly justified, especially in situations of limited economic resources.

Morbidity is high with zoster in below 2 years of age and in above 12 years of age, so oral acyclovir given at a dose of 20–40 mg/kg body weight, four times a day for 7 days is recommended.



# Crossword - Picking the Big Brains



## Down:

1. satellite pustules in a nappy rash
2. Hair involvement in Waardenburg syndrome
3. Boggy alopecia on scalp
4. Hyperkeratotic papules on extremities with dry skin
5. Exanthem subitum
7. Calcified hamartoma from hair follicle
9. Palpable purpuric rash, abdominal pain and arthritis in a child
12. Honey colored crusting
16. Pruritic linear psoriasiform birthmark

## Across:

6. Nail involvement in Hand, foot and mouth disease
8. Grouped lichenoid pin point eruption
10. Looking for Incontinentia Pigmenti mutation
11. Annular patch followed by a symmetric truncal rash
13. Juvenile melanoma
14. Bamboo hair and double colarette scale will clinch this syndrome
15. Crystalline rash in summers



## How I treat molluscum contagiosum

**Dr Angoori Gnaneshwar Rao**

Prof & HOD Department of Dermatology, SVS Medical College,  
Hyderabad

- Leaving mollusca to spontaneously resolve is often reasonable, especially in young children for whom freezing or curettage may be painful and frightening.
- Molluscum contagiosa lesions on face are best treated with minor trauma. Direct trauma to molluscum lesions frequently produces an inflammatory response and resolution of the lesion. Various modes of inducing local trauma include chemical agents like topical tretinoin, salicylic acid, and potassium hydroxide, cantharidin, silver nitrate, trichloroacetic acid, and phenol. Children may tolerate therapy with these agents better than curettage or cryotherapy.
- Tretinoin cream: Topical Tretinoin cream 0.05%-0.1% is applied twice daily. Resolution usually occurs in 2 weeks.
- Potassium hydroxide(KOH): Potassium hydroxide is a strong alkali that has long been known to digest proteins, lipids, and most other epithelial debris of skin. Topical 10% KOH aqueous solution applied twice daily or 20% KOH applied once daily on each lesion until all lesions undergo inflammation and superficial ulceration.
- Cantharidin is a chemovesicant that is highly effective in treating molluscum contagiosum.
- Various physical modes of inducing trauma include curettage, expression of the central core with tweezers, rupture of the central core with a needle (extirpation), electrodesiccation cryotherapy, lasers, photodynamic therapy.
- Curettage can be used in case of multiple lesions, children usually need prior application of topical anaesthetic cream. May be associated with complications like scarring.
- Cryotherapy is effective in older children, repeated at 3-4 weekly intervals.
- CO2 laser and pulsed dye laser are also useful, can cause scars
- Antiviral agents like Cidofovir (used either topically as 1-3% cream or intravenously ) – effectively resolves molluscum lesions. Considered for treating extensive lesions in immunocompromised individuals.

# ADOLESCENT PRESENTING WITH ALOPECIA TOTALIS – HOW I MANAGE AND COUNSEL HIM/HER AND THE PARENTS.

Dr Vibhu Mendiratta, Director Professor, Lady Hardinge Medical College and Assoc.  
Kalawati Saran Children's Hospital ,New Delhi -1

- A Alopecia areata (AA) is characterized by nonscarring hair loss in patches of typically well-demarcated smooth skin, most commonly involving scalp, also can affect eyebrows, eyelashes, beard and body hair. Involvement varies from a single patch to multiple patches or total hair loss. Alopecia totalis (AT) involving the entire scalp and hair such as eyebrows, eyelashes, beard, axillary hair and pubic hair and alopecia universalis (AU) if the total body hair is involved. Twenty percent of cases were children, and 60% of AA patients had their first patch before 20 years of age. (1) 5-10% of patchy AA may progress to AT/AU. If AA develops before puberty, the risk of AT is 50% and in older individuals, the risk is about 25%.(2)

Alopecia is a form of disfigurement that can affect a person's sense of self and identity. There has been little attention in the literature to the psychosocial consequences of alopecia areata in children. Patients with extensive alopecia areata had psychiatric comorbidity, mainly adjustment disorders, generalized anxiety disorder, and depressive episodes. A small case-control cross-sectional study in children with alopecia areata compared with control children who visited a pediatrician "for a mild condition," reported that the children with alopecia were more anxious, depressed, withdrawn, aggressive, and/or delinquent. They had more inattention, somatic complaints, and problems in social relations. Girls with alopecia appeared to more adversely psychologically affected than boys.(3) Adolescence is a special age where there is heightened awareness of self image and social networking.

In study by Qi et al, AA moderately affected the quality of life of the patients. Patients with alopecia totalis/alopecia universalis, longer duration, local symptoms, and recurrent disease exhibited higher scores of mean DLQI (4)

## DEALING WITH ADOLESCENT PATIENT HAVING ALOPECIA TOTALIS

Recognition of possible psychological problems accompanying alopecia is important and such problems need to be dealt with care and support. Given that medical treatment for the more severe forms of alopecia is largely ineffective, it is critical that the person is helped to learn to live with the disorder and dissuaded from searching fruitlessly for a "cure." This may mean referral to psychological services (3)

With the given background of alopecia totalis , I feel it is imperative on the part of the treating dermatologist to hold separate , exclusive dialogue with both the parents and the patient discussing the nature, course and effect of treatment on the disease. I would counsel the parents separately regarding the success rate of treatment , the pros and cons of each modality in order to enable them to undertake an informed decision as to select treatment modality and whether to go ahead with treatment or to resort to hair pieces considering the relapsing nature of the disease.

The second end of the problem is the patient (adolescent ) who needs a sensitive approach . It may mean a couple of meetings with dedicated time for the patient to have an objective assessment of impact of the disease on QOL / associated psychological morbidity which could be hampering normal life. Again explaining the recurrent nature of the disease in all honesty must be attempted. The long term prognosis along with the side effects and response rate of each modality are also discussed in detail..The treatment offered depends largely on the willingness and the combined decision taken by parents and the patient.

## TREATMENT

Lab tests are considered based on history and chosen treatment modality. G6PD test, liver function tests, complete blood cell count, chemistry profile, urinalysis, levels of thyroid hormones, fasting blood sugar, and antinuclear antibody titers (ANA) .

- 1 Specific Agents- I use oral steroids ( betamethasone, dexamethasone , methyl prednisolone ) as weekly pulse therapy along with daily sulfasalazine ( 1-1.5 grams /day ) or weekly methotrexate ( 7.5mg – 12.5 mg /week) for a period of 3-6 months . Once the hair growth appears the steroids are tapered off and the adjuvant is further continued for next 6 months. However the patient and parents are well informed about the relapsing nature prior to starting treatment as relapse is expected after stopping steroids.

- 2 I/V pulses – monthly- In some patients who are really motivated for treatment and also have profound psychological impact on their quality of life. I use 15-30 mg/kg methyl prednisolone/ as intravenous pulse steroid monthly for 6 months along with methotrexate introduced in the last 3 months . The corticosteroid preparation is dissolved in 150-200 ml of 5% dextrose and infused intravenously, slowly over 2-3 hours. Methotrexate is continued for another 6 months. Dexamethasone is used as a cheaper alternative in the dose of 4-5 mg/kg /day ( 50-100 mg ) I/V monthly for 6 months then used as maintenance therapy for once in 3 months for 9-12 months. (6)
- 3 Azathioprine is also employed in some cases in place of methotrexate.
- 4 Cyclosporin ( 2.5mg-3.5mg/Kg/ day ) also produces good hair growth.
- 5 I don't use topical immunotherapy in my patients
- 6 Relaxation techniques and anxiolytics in consultation with psychiatry are also used in some cases.
- 7 Psychotherapy and antidepressants if required as decided by the psychiatrist (Antidepressants have been reported in case reports to both cause and benefit alopecia areata. In a very small double-blind, placebo-controlled trial, patients taking imipramine 75 mg/day had significantly more hair regrowth than did control subjects, an effect that was independent of reductions in anxiety or depression.
- 8 Supplements- vitamin D, zinc and biotin
- 9 Treatment of associated autoimmune diseases- Any underlying thyroid dysfunction ( hypothyroidism/ hyperthyroidism ) is investigated and treated .
- 10 Newer promising drugs on the horizon- Tofacitinib ( XELIZENZ) – Have not used in my patients but the drug has shown promising results in alopecia totalis and universalis in adolescents (7) . The cost is very high .

## CONCLUSIONS

Doctors should be aware of the psychological impact of alopecia, especially as current treatments have limited effectiveness. Providing treatment that is unlikely to be effective may do more psychological harm than medical good. Doctors also need to help the patient to understand their alopecia and their psychological responses to the disorder. They can do this partly by providing appropriate information (including about changing one's appearance through, for example, wigs and tattoos). Psychological symptoms must be enquired for and addressed by using recommended treatment strategies.(3)

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## How I treat warts

**Dr Angoori Gnaneshwar Rao**

Prof & HOD Department of Dermatology, SVS Medical College,  
Hyderabad

**Multiple modalities are available for the treatment of warts, but none is uniformly effective.**

- Start with the least painful, least expensive, and least time-consuming methods.
- Reserve the more expensive and invasive procedures for refractory extensive warts. Immunosuppressed individuals often are refractory to wart treatments.
- Topical therapy:
  - Salicylic acid – (12-26%) Keratolytic, in combination with lactic acid and collodion is the best preferred first-line choice for common and plantar warts. Not suitable for use in extensive warts because of potential risk of systemic toxicity especially in children
  - Trichloroacetic acid (TCA)- causes chemical coagulation of cellular proteins, destroys HPV DNA. Topical TCA 50% once or twice weekly is useful. Burning sensation, pain and acid burns are common adverse effects.
  - Topical Retinoids- Useful in plane warts. Tretinoin (0.025%, 0.05%, 0.1%) applied at bed time daily, useful mainly with diffuse flat warts on face.
  - Glutaraldehyde (10%)- Has virucidal properties, useful for warts on feet
  - Formalin- Soaks or compresses of 2-3% formalin in water, may be effective in plantar warts. Reported cure rate of 80% in children.
  - Cantharidin- chemovesicant- effective in common and plantar warts.
  - Topical 5-Fluorouracil (5-FU)- effective in recalcitrant warts.
- Electrosurgery – better option, high clearance rates.
- Radiofrequency- effective in 90% cases
- Cryotherapy- cheap, effective, easy to administer; gives best results in periungual and plantar warts.
- Intralesional injections: Useful for extensive, persistent and refractory warts.
  - Intralesional immunotherapy using injections of Vitamin D, MMR, BCG, Candida, Trichophyton skin test antigens has been shown to be effective in the treatment of warts,
  - Bleomycin is a chemotherapeutic agent that inhibits DNA synthesis in cells and viruses. Cure rates range between 33-92%.
  - Interferon-alfa is a naturally occurring cytokine with antiviral, antibacterial, anticancer, and immunomodulatory effects.

## Upcoming Pediatric Dermatology Events

Dr Ram Gulati

1. The Society for Pediatric Dermatology, 44th Annual Meeting July 11-14, 2019, Austin, Texas, USA
2. PedDerm-Con, SIG Pediatric Dermatology IADVL/IADVL Academy/ IADVL Telangana, July 27-28, 2019, Hyderabad, India
3. Indian Society of Pediatric Dermatology, Annual Conference, Sep 13-14, 2019, Agra, India
4. 14th World Congress on Pediatric Dermatology. Sep 22-25 2019, Edinburgh, Scotland, UK
5. Pediatric Dermatology Research Alliance, Annual Conference, Nov 14-16, 2019, Chicago, Illinois, USA

## Humour in Dermatology

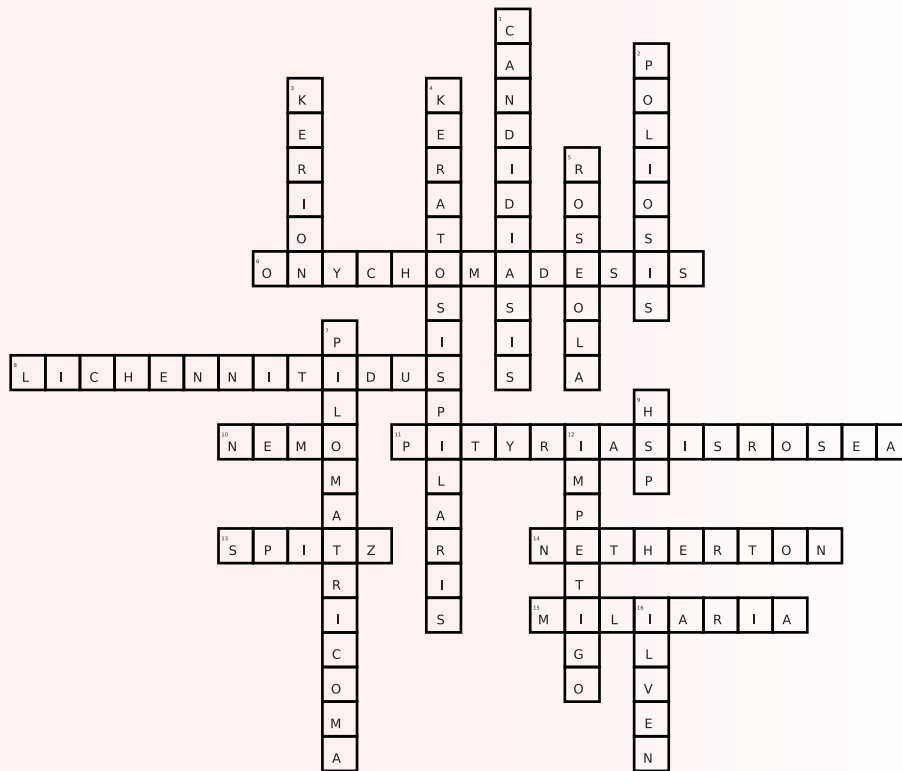
Dr Ram Gulati

### Acne: you are still young!

She was beautiful, she was fair  
With a flawless face and silky long hair  
When she smiled, the cuckoo sang  
Flowers blossomed and the bells rang  
When the teeth shone, one could appreciate the dimple  
But then the misfortune struck, she saw a pimple  
O my God, from where has it come  
Somebody tell me, O' dad O' mum  
It was red, with a small white head  
Staring in the mirror, she almost went dead  
"I was absolutely perfect, when I slept in the night  
But this morning, tis' my life's biggest fright  
This ugly monster, as it looks like  
Melt it fast, lest the blood pressure may hike"  
So before the situation reached a point  
When she would have to be resuscitated  
She was rushed to a dermatologist  
To get some treatment instigated  
In a jiffy, she opened the doc's door  
"Treat this" she screamed, "or I'll be no more"  
Doctor was taken aback, with this ransack  
But managing to smile, he pointed out  
"Relax lady, probably you have a psychiatric bout"  
Mercury shot up, and temperament ran high  
"Can't you see this doctor, this ugliest thing under the sky"  
As the fog drifted, the situation became clear  
Ironically, the doc was now more in fear  
"If I don't treat this quick, and clear the face fast,  
Next visit I know what she'll do, I would be thing of the past"  
With shaky hands, the prescription was handed  
After a fortnight, in follow-up she landed  
To doc's utmost relief, the monster was no more  
Drug had worked, but for new red spots on forehead numbering four  
Doctor knew the hormones were on the ride  
With intentions of sebum malefide  
Every time he relaxed her, kept on changing medication  
But there was no short cut to their eradication  
Years went by, she is now in her middle  
With no spots, for her "acne is no more a riddle"  
Now she says just don't fear  
When you've got the spots, enjoy my dear  
For these are not monsters, these are heroes unsung  
They remind you time and again, that you are still young.

\*\*\*\*\*

# Crossword - Picking the Big Brains



## Down:

1. satellite pustules in a nappy rash
2. Hair involvement in Waardenburg syndrome
3. Boggy alopecia on scalp
4. Hyperkeratotic papules on extremities with dry skin
5. Exanthem subitum
7. Calcified hamartoma from hair follicle
9. Palpable purpuric rash, abdominal pain and arthritis in a child
12. Honey colored crusting
16. Pruritic linear psoriasiform birthmark

## Across:

6. Nail involvement in Hand, foot and mouth disease
8. Grouped lichenoid pin point eruption
10. Looking for Incontinentia Pigmenti mutation
11. Annular patch followed by a symmetric truncal rash
13. Juvenile melanoma
14. Bamboo hair and double colarette scale will clinch this syndrome
15. Crystalline rash in summers



