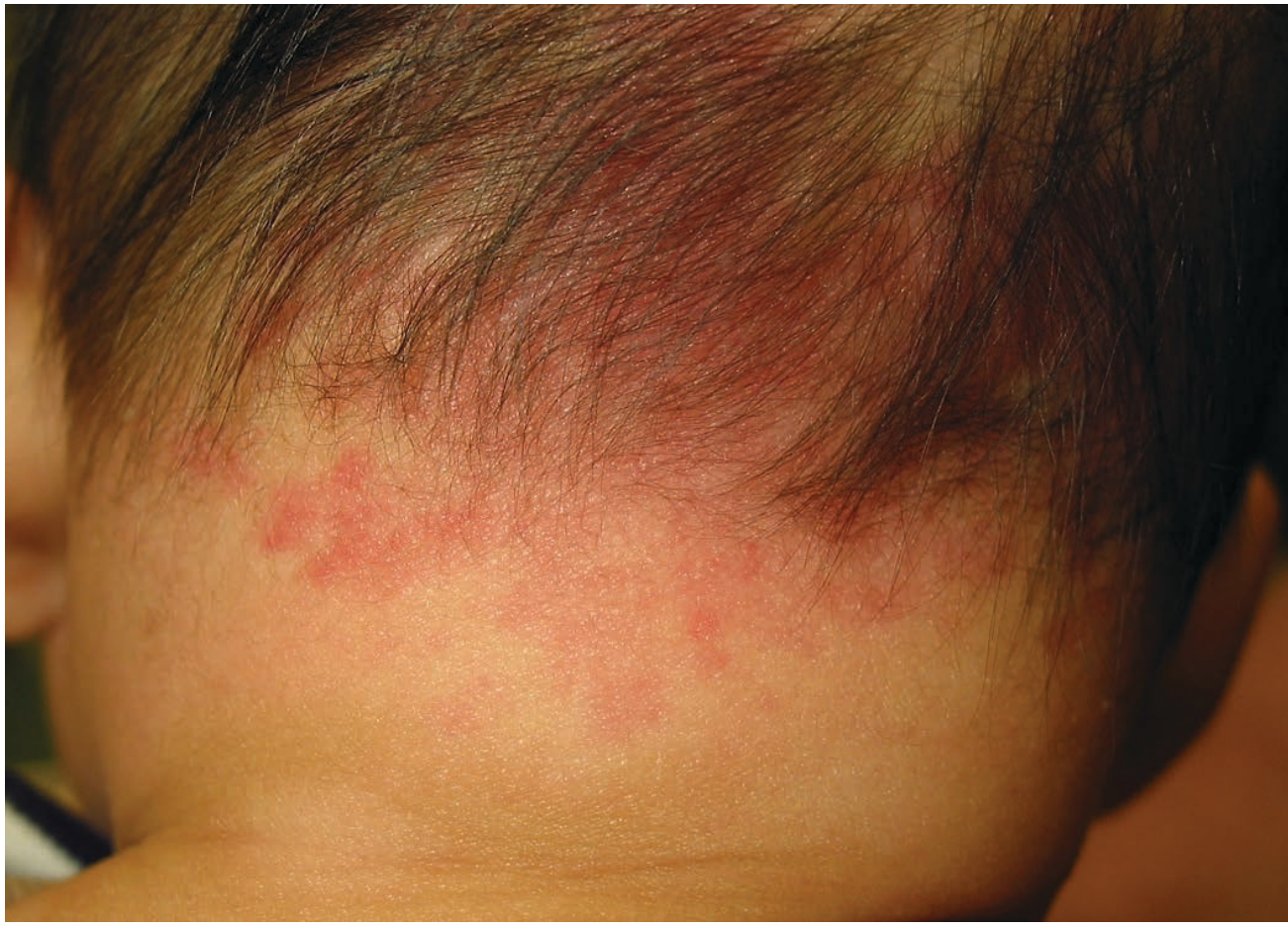
Foresee Your Next Patient



Salmon Patches

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A 6-week-old newborn presented with red patches on the occipital area and nape of his neck. The lesions had been first noted at birth. He had been born at term to a gravida 1, para 0, 20-year-old mother following an uncomplicated pregnancy and normal vaginal delivery. During the pregnancy, the mother had not been on any medication and did not smoke or consume alcohol. The newborn's Apgar score was 6 at 1 minute and 9 at 5 minutes. The neonatal course had been uneventful.

On examination, erythematous patches were noted in the occipital area and nape. The color of the lesions deepened with crying. The rest of the examination findings were normal. A diagnosis of salmon patches was made. The parents were reassured that the condition is benign and that treatment was not necessary.

Salmon patches, also known as nevus flammeus simplex, are the most common vascular lesions in infancy.[1] Colloquially, the lesions on the forehead and eyelids are known as "angel's kisses" and the ones in the occipital area as "stork bites."[1]

Prevalence: In the white population,

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salmon patches are present in approximately 44% of all neonates.[2] They are less common in dark-skinned neonates.[2] Both sexes are equally affected.[3] Salmon patches tend to fade with time and, with the exception of the nuchal ones, are rarely detected after the age of 6 years.[2]

Pathogenesis: Presumably, salmon patches are composed of ectatic dermal capillaries that represent the persistence of fetal circulating patterns in the skin.[2]

Clinical manifestations: The lesions are scarlet to pink, flat, can be totally blanched, and usually deepen in color with vigorous activity, crying, straining with defecation, breath-holding, or changes in ambient temperature.[4] In white infants, they usually are bright red or pink and are darker in Asian or black infants.[4] The lesions most commonly are found on the nape, followed by the glabella and eyelids.[3] Other less common sites are the nasolabial folds, lips, and sacral area.[5] Salmon patches usually are symmetric, with lesions on both eyelids or on both sides of the midline.[6]

Prominent lesions in the glabella may be associated with Beckwith-Wiedemann syndrome and fetal alcohol syndrome.[1,7] Salmon patches generally are not associated with extracutaneous anomalies.[5] In spite of their midline location, most salmon patches, except those in the sacral area, are not associated with spinal dysraphism.[6]

Diagnosis: The diagnosis of salmon patches is clinical, and no laboratory testing is necessary.

The condition should be differentiated from port-wine stain (nevus flammeus), congenital medial frontofacial capillary malformation, and nevus roseus.[8] Port-wine stain is a capillary malformation characterized clinically by persistent macular erythema and pathologically by ectasia of the papillary and superficial reticular dermal capillaries, which are otherwise lined by normal-appearing flat endothelial cells.[1] The capillaries become more ectatic with age, and the color gradually deepens.[1] The lesions of port-wine stain usually are unilateral and segmental and do not follow the lines of Blaschko.[1]

Congenital medial frontofacial capillary malformation simulates a salmon patch but differs in that the lesion is more extensive, extending from the forehead and glabella to the nose, philtrum, and upper lip; the color is more intense; and the lesion fades more slowly or incompletely.[8] Familial cases of congenital medial frontofacial capillary malformations have been reported.[9]

Nevus roseus is a lateralized telangiectatic birthmark characterized by a light red or pale pink color, contrasting with the dark line of nevus flammeus.[10] The lesion tends to be arranged in a checkerboard pattern.[10]

Management: Treatment consists of reassuring parents that the lesion will disappear or significantly regress with time.[3] Salmon patches on the eyelids and glabella usually disappear by 2 to 3 years of age.[2] Nuchal and sacral lesions tend to persist longer.[11] Because of the possible association with occult spinal dysraphism, it is recommended that routine ultrasonography imaging of the lumbosacral spine be performed in neonates with salmon patches in the sacral area.[5] ■

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Eczema Herpeticum With Atopic Dermatitis

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A 15-month-old girl with a history of poorly controlled atopic dermatitis presented with erythema and scattered lesions around her right eye. Four days before presentation, the child was noted to have 2 small macules near the eye, which her foster mother attributed to an eczema flare-up. Over the ensuing 4 days, the eyelid became progressively erythematous, and the number of lesions increased. The lesions were associated with some eyelid swelling and scant yellowish discharge. There were no reported fevers, cough, nasal congestion, ear tugging, or change in appetite.

On physical examination, the patient was afebrile, with a temperature of 37.2°C. She exhibited apprehension during the examination, typical of patients her age, but she was easily consolable by her foster mother.

The girl had a number of grouped vesicular lesions on the right upper and lower eyelids. Some vesicles had crusted over. An open lesion was present on the right upper eyelid. There were no apparent lesions on the surface of the sclera or cornea, and there was no scleral injection. There was no photophobia. A minimal amount of dried, yellow drainage was observed on the right medial canthus. There were no lesions or erythema