Correspondence

Archives of Disease in Childhood, 1976, 51, 733.

Treatment of generalized seborrhoeic dermatitis

Sir,

It is always gratifying to learn of a new treatment for a troublesome dermatosis, especially if the pharmacological agent is relatively nontoxic. It was therefore with great interest that we read the results of biotin treatment for napkin dermatitis in an infant with either an atopic or psoriatic diathesis. Rare systemic infections would be a co-existent thrush, and rectal cultures may show high colony counts of Candida (Dixon et al., 1969). Moreover, many cases present with a history that the diaper component appeared during or immediately after a course of broad spectrum antibiotics with the subsequent development of a disseminated eruption. Dr. Messaritakis relates that his patients usually had involvement earliest in the napkin area and also that most had had treatment with antibiotics before admission. Although skin cultures were taken, we are not told from which areas.

The clinical descriptions and the microbiological data presented are insufficient to allow a definitive diagnosis. However, it is our suspicion that most of the patients in Dr. Messaritakis’s study have the phenomenon of napkin dermatitis with i’d reaction. It would be of interest to follow these patients to observe the probable emergence of atopic dermatitis, seborrhoeic dermatitis, or psoriasis in the future.

ALLEN GAISIN, JAY M. HOLZWANGER,
and JAMES J. LEYDEN
Section of Dermatology,
Children’s Hospital of Philadelphia,
and Department of Dermatology,
Hospital of the University of Pennsylvania,
Philadelphia, Pennsylvania, U.S.A.

REFERENCES

extremities. In Neville and Finn’s follow-up study (1975), 17% of those children who presented with a psoriasiform ‘id’ later developed true psoriasis and 37% of those with the flexural scaling ‘id’ later developed atopic dermatitis. Therefore, when a sudden generalized eruption appears in an infant with napkin dermatitis, a careful family history and dermatological examination must be undertaken to search for atopic disease or psoriasis in family members and other stigmata of atopy and/or psoriatic nail pitting in the infant.

The question of what infectious agent(s) may be involved has stirred much controversy over the years and is still under active investigation in our lab (Warin and Faulkner, 1961; Perlman, 1962; Jefferson, 1967; Dixon et al., 1969; Montes et al., 1971). It was well known that Candida albicans may be isolated early in the napkin area in a significant percentage of cases, but not from distant sites. There may frequently be a co-existent thrush, and rectal cultures may show high colony counts of Candida (Dixon et al., 1969). Moreover, many cases present with a history that the diaper component appeared during or immediately after a course of broad spectrum antibiotics with the subsequent development of a disseminated eruption. Dr. Messaritakis relates that his patients usually had involvement earliest in the napkin area and also that most had had treatment with antibiotics before admission. Although skin cultures were taken, we are not told from which areas.

The clinical descriptions and the microbiological data presented are insufficient to allow a definitive diagnosis. However, it is our suspicion that most of the patients in Dr. Messaritakis’s study have the phenomenon of napkin dermatitis with i’d reaction. It would be of interest to follow these patients to observe the probable emergence of atopic dermatitis, seborrhoeic dermatitis, or psoriasis in the future.

ALLEN GAISIN, JAY M. HOLZWANGER,
and JAMES J. LEYDEN
Section of Dermatology,
Children’s Hospital of Philadelphia,
and Department of Dermatology,
Hospital of the University of Pennsylvania,
Philadelphia, Pennsylvania, U.S.A.

REFERENCES

over the past 20 years there have been a number of reports emphasizing the striking seborrhoeic dermatitis-like eruption that occasionally appears in association with severe diaper dermatitis. This entity has been called ‘seborrhoeic diaper reaction’ (Perlman, 1962), ‘seborrhoeic dermatitis with moniliasis’ (Jefferson, 1967), ‘napkin dermatitis with psoriasiform “id” ’ (Fergusson, Fraser, and Grant, 1966) and ‘psoriasiform napkin dermatitis’ (Andersen and Thomsen, 1971). Warin and Faulkner (1961) believed psoriasis to be the most common cause, and Neville and Finn (1975) found on re-evaluating patients 5–13 years later that atopic dermatitis and psoriasis were the most frequent aetiologies.

We believe that a severe diaper dermatitis may trigger an explosive generalized cutaneous eruption in infants born with a predisposition to atopic dermatitis, psoriasis, or seborrhoeic dermatitis. This may take the form of erythematous papuloussquamous lesions with a yellowish greasy scale involving the scalp and flexural creases of the neck, axillae, and groin area. Also, discrete psoriasiform plaques may be present on the trunk, face, and extremities. In Neville and Finn’s follow-up study (1975), 17% of those children who presented with a psoriasiform ‘id’ later developed true psoriasis and 37% of those with the flexural scaling ‘id’ later developed atopic dermatitis. Therefore, when a sudden generalized eruption appears in an infant with napkin dermatitis, a careful family history and dermatological examination must be undertaken to search for atopic disease or psoriasis in family members and other stigmata of atopy and/or psoriatic nail pitting in the infant.

The question of what infectious agent(s) may be involved has stirred much controversy over the years and is still under active investigation in our lab (Warin and Faulkner, 1961; Perlman, 1962; Jefferson, 1967; Dixon et al., 1969; Montes et al., 1971). It was well known that Candida albicans may be isolated early in the napkin area in a significant percentage of cases, but not from distant sites. There may frequently be a co-existent thrush, and rectal cultures may show high colony counts of Candida (Dixon et al., 1969). Moreover, many cases present with a history that the diaper component appeared during or immediately after a course of broad spectrum antibiotics with the subsequent development of a disseminated eruption. Dr. Messaritakis relates that his patients usually had involvement earliest in the napkin area and also that most had had treatment with antibiotics before admission. Although skin cultures were taken, we are not told from which areas.

The clinical descriptions and the microbiological data presented are insufficient to allow a definitive diagnosis. However, it is our suspicion that most of the patients in Dr. Messaritakis’s study have the phenomenon of napkin dermatitis with i’d reaction. It would be of interest to follow these patients to observe the probable emergence of atopic dermatitis, seborrhoeic dermatitis, or psoriasis in the future.

ALLEN GAISIN, JAY M. HOLZWANGER,
and JAMES J. LEYDEN
Section of Dermatology,
Children’s Hospital of Philadelphia,
and Department of Dermatology,
Hospital of the University of Pennsylvania,
Philadelphia, Pennsylvania, U.S.A.

REFERENCES
Watery diarrhoea and ganglioneuroma

Sir,

We read with interest the case report by Swift, Bloom, and Harris (1975) of a 5-year-old girl with watery diarrhoea and a vasoactive intestinal peptide (VIP) secreting ganglioneuroma. In April 1975 we reported raised levels of VIP in a child with chronic watery diarrhoea and hypokalaemia (Udall et al., 1975). The syndrome of intractable watery diarrhoea and hypokalaemia associated with pancreatic tumors was first described by Verner and Morrison (1958). Chronic watery diarrhoea and hypokalaemia has more recently been reported associated with pancreatic islet cell hyperplasia, neurogenous tumours, bronchogenic carcinomas, pheochromocytoma, and ganglioneuroblastoma. The syndrome now has been associated with increased serum and/or tumour tissue levels of VIP (Bloom, Polak, and Pearse, 1973; Said and Faloona, 1975). There is evidence that the tumours may arise from cells that share a common derivation from the neural crest (Said and Faloona, 1975). Such cells (APUD) have a number of similar histochemical and ultrastructural characteristics (amine precursor uptake and decarboxylation) and also the capacity to secrete polypeptide hormones. There are many questions that remain unanswered since intractable watery diarrhoea and hypokalaemia in our patient and one reported by Pabst et al. (1969) was not associated with pancreatic hyperplasia or neoplasia. Serum VIP has also been shown recently to be increased in cholera (D. Nailand, personal communication). The significance of this peptide in diarrhoeal states awaits further investigation.

JOHN N. UDALL JR., GEORGE D. FERRY, and BURFORD L. NICHOLS
Section of Nutrition and Gastroenterology, Department of Pediatrics, Baylor College of Medicine, Texas Medical Center, Houston, Texas 77025, U.S.A.

REFERENCES