

TABLE 1. Number of Community Visits Performed by the Pediatric Dermatology Nurse Specialist (PDNS) (home, school, GP)

	Eczema	Psoriasis	Allergy	Other conditions	Total number of patients
Home visits	54	0	8	7	69
School/nursery visits	3	0	6	0	9
General practitioner visits	1	0	0	0	1
<i>n</i>	58	0	14	7	79

TABLE 2. Table Demonstrating Liaison Work (telephone calls/letters) Performed by Pediatric Dermatology Nurse Specialist (PDNS)

Method of correspondence	Parents	School nurses/ teachers	Health professionals	Social services/ agencies	Total number
Telephone calls	19	13	17	4	53
Letters	3	4	2	9	18
Total	22	17	19	13	71

clinic availability, more aggressive treatment modalities, and less availability of dermatology beds could also contribute to this finding. Despite the numbers of doctors in clinic remaining unchanged in the 2 years recorded, new patient reviews in the outpatient clinic in 2005 to 2006 increased by 70%, most likely due to the PDNS seeing almost 1/3 of the follow up patients in this year. There were no other changes in clinic operations that could account for this change.

It is widely accepted that family quality of life and disease severity in atopic children is directly related (4) and it is imperative therefore that care of patients with eczema include consideration of the whole family. Home visits therefore remain an essential part of our PDNS's role ($n = 54$).

In conclusion, we accept that we have not performed cost analyses and have only examined 12 months of the PDNS's work. We also appreciate that the actions of one individual may not be mirrored by others. However, we do feel we have shown that the PDNS is an integral part of the dermatology team and must remain supported.

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EFFECTS OF SKIN CARE WITH SHOWER THERAPY ON CHILDREN WITH ATOPIC DERMATITIS IN ELEMENTARY SCHOOLS

Abstract: For elementary school children with atopic dermatitis, a skin care program using shower therapy was performed during the school lunch break for 6 weeks from June to July in 2004 and 2005. All 53 participants showed an improvement in their atopic dermatitis during the 6-week periods studied. Skin care with daily showering at an elementary school was thus found to be effective for the treatment of atopic dermatitis.

Atopic dermatitis in elementary school children may often be difficult to control with standard therapy. Skin itching may be exacerbated by sweat, sand, and dust induced by physical education and games during a normal school day (1), which can exacerbate dermatitis. We examined the effects of a skin care regimen using showers with plain water in the early summer season, a time when heat and perspiration are believed to aggravate dermatitis.

Skin care with shower therapy was performed during school lunch breaks for 6-week periods from June to July in 2004 and 2005, and evaluations of skin lesions was performed every 2 weeks by nurse-teachers (school nurses). Fifty-four children in seven elementary schools in Gunma prefecture, Japan, participated in this study. No other on-going atopic dermatitis therapies were modified during the study period. Observations of patient's parents and nurse-teachers were recorded after the conclusion of the study period.

When shower therapy was used, no soap or shampoos were used, and topical treatments were used after the shower. We evaluated the effect of the shower

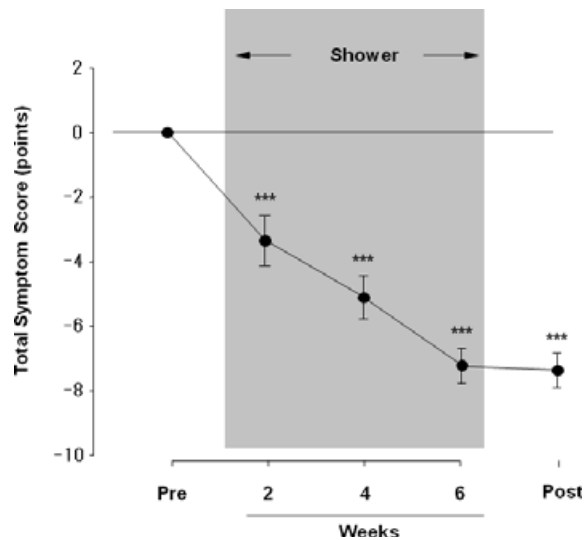


Figure 1. Changes in atopic dermatitis symptom score during the 2-year study period.

therapy by observing changes in skin lesions, using the atopic dermatitis symptom score (2). The body was divided into 25-block units and each block unit scored with a zero to two point scale: erosion or strongly scratched eczema; 2 points, normal skin; 0 points, and between these extremes, 1 point. Five phases of change over time were recorded: marked aggravation, aggravation, no change, improved, and markedly improved. Evaluations were performed every 2 weeks by the nurse-teachers who directed the skin care with shower and by the patient's parents when the study finished. A parametric analysis of variance (ANOVA) was performed to assess any differences in the symptom scores between the groups.

During this study, 53 of the 54 patients were given showers for 6 weeks. Each individual patient demonstrated a significant improvement of their skin lesion. In this study, we did not check the amount of medication used, because we explained to the parents that "other on-going therapies should not be changed during this examination" at the starting point. However, two parents in fact did decrease the medication because of an improvement in the skin lesions, and we did not delete these data. The clinical symptom score gradually decreased every 2 weeks, and reaching a minimum at 6 weeks for both years. The summarized data of the first and the second years are shown in the Fig. 1, thus illustrating a significant decrease in the symptom score from the base line during the shower therapy study at 2, 4, 6 weeks in comparison with the score in pretreatment ($p < 0.05$, $p < 0.01$, $p < 0.001$, respectively). Many parents reported that they wanted to continue the shower

TABLE 1. Parental Comments in 53 Patients

Skin lesion	Marked improvement	9 (17%)
	Improvement	39 (74%)
	No change	5 (9%)
	Aggravation	0 (0%)
Itching	Marked aggravation	0 (0%)
	Marked improvement	8 (15%)
	Improvement	39 (74%)
	No change	6 (11%)
Clinical impression*	Aggravation	0 (0%)
	Marked aggravation	0 (0%)
	Improvement of itching	19 (36%)
	Marked decrease of scratch	11 (21%)
Free comments*	Marked decrease of irritancy	6 (11%)
	Volition to skin care	5 (9%)
	Good sleep	3 (6%)
	Decrease of medicine	2 (4%)
Free comments*	Others or no answer	7 (13%)
	Hope to continue shower bath	34 (64%)
	Marked improvement	9 (17%)
	Thanks to teachers	4 (8%)
Free comments*	Hope to spread shower bath	3 (6%)
	Others or no answer	3 (6%)

*Almost parents replied a single answer in clinical impression and free comments.

therapy in the elementary schools (Table 1), and nurse-teachers in seven elementary schools also reported that the shower therapy had a positive effect on the treatment of atopic dermatitis in the elementary schools.

Guidelines, which have been published for its effective management of atopic dermatitis (3,4), indicate that basic therapy includes the avoidance of triggering factors and conducting appropriate skin care. However, there are no evidence-based reports that demonstrate a significant effect of skin care and a practical method of skin care that can be administered in elementary school. This study confirmed that skin care using shower therapy during the normal elementary school day appears to be an effective and useful treatment for atopic dermatitis. For the continuing treatment of atopic dermatitis in elementary school children, routine skin care using showers should be considered.

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CONGENITAL HEMANGIOMA: A REPORT OF EVOLUTION FROM RAPIDLY INVOLUTING TO NONINVOLUTING CONGENITAL HEMANGIOMA WITH ABERRANT MONGOLIAN SPOTS

Abstract: Congenital hemangiomas are unusual vascular tumors that are fully developed at the time of delivery. We report a case of an infant with an exophytic congenital hemangioma with features of a rapidly involuting hemangioma on the arm which over 3 years decreased in volume but continued to persist with features of a noninvoluting congenital hemangioma. He also had aberrant, persistent Mongolian spots on both legs. To our knowledge, this association has not been reported to date.

Congenital hemangiomas are rare vascular tumors that are fully formed at birth without accelerated postnatal growth (1). Two forms of congenital hemangiomas have been described: rapidly involuting congenital hemangioma (RICH) and noninvoluting congenital hemangioma (NICH). Mongolian spots (a form of dermal melanocytosis) are most frequently located in the sacral region. Aberrant Mongolian spots refer to the presence of these lesions in extrasacral locations. We report a case of a congenital hemangioma evolving from features of RICH to NICH in association with aberrant Mongolian spots.

CASE REPORT

A 6-day-old white male infant was referred for evaluation of a congenital nodule. On examination, a well defined 35 × 30 × 10 mm nodular lesion involving his left cubital fossa was noted. It had a purple tinge with coarse telangiectasias on the surface and no thrill was palpable (Fig. 1A). Doppler ultrasonography demonstrated a fast-flow hypoechoic vascular mass with

arterio-venous microshunts. A diagnosis of congenital hemangioma was suspected. Echocardiogram showed no abnormalities and platelet count was within normal limits. He was also noted to have extensive greyish-blue hyperpigmentations on the lateral aspect of his legs consistent with aberrantly-located Mongolian spots (Fig. 2). Over time, slow and progressive decrease in the vascular mass was observed, but at 34 months of age the lesion still persisted as a nearly flat pale pink plaque, with peripheral blanched halo and telangiectasias (Fig. 1B). The areas of aberrant Mongolian spots had faded but were persistent.

DISCUSSION

Congenital hemangiomas are much less common than infantile hemangiomas. They present as raised violaceous tumors with large radial veins, hemispheric tumors with multiple tiny telangiectasias and a pale rim, or pink-to-violaceous tumors firm to palpation (2), and with both Doppler and angiographic examination are noted by high-flow vascular masses. On angiography, large and irregular feeding arteries, arterial aneurysms and direct

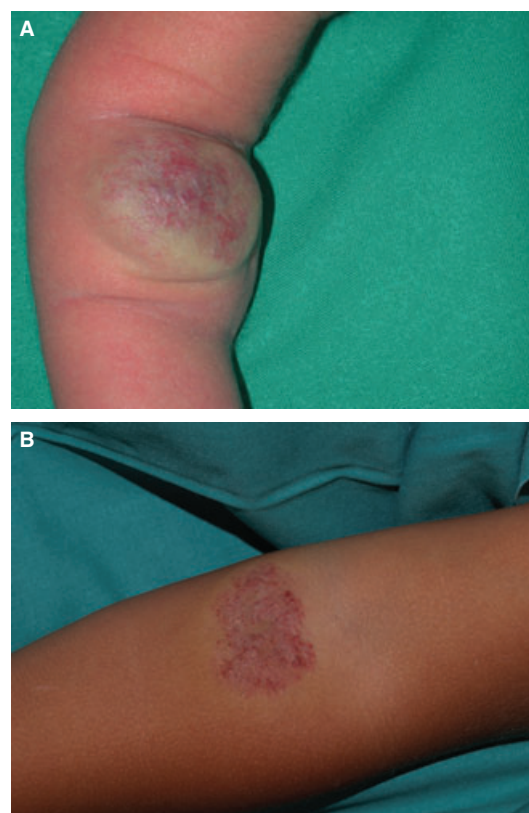


Figure 1. Bossed tumor with coarse telangiectasias on the cubital fossa at birth (A), flattened plaque with fine telangiectasias at 34 months of age (B).