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CLINICAL AND DIFFERENTIAL DIAGNOSIS OF FREQUENTLY ENCOUNTERED DERMATOSES IN PEDIATRIC PRACTICE

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Abstract
Skin diseases constitute 6-24% of all pediatric consultations worldwide. The most frequently encountered dermatoses in children - atopic dermatitis, seborrheic dermatitis, impetigo, scabies, tinea corporis, psoriasis, and molluscum contagiosum - share overlapping morphological features that complicate clinical differentiation. Accurate diagnosis requires systematic integration of age at onset, lesion distribution, associated symptoms, family history, and targeted laboratory investigations including microscopy, bacterial culture, and dermoscopy. This review presents quantitative epidemiological data and evidence-based differential diagnostic criteria for the most common pediatric dermatoses.

Keywords: pediatric dermatology, atopic dermatitis, seborrheic dermatitis, impetigo, scabies, tinea corporis, psoriasis vulgaris, molluscum contagiosum, SCORAD index, Hanifin-Rajka criteria, dermoscopy, KOH microscopy, differential diagnosis, skin of color, epidermal barrier

Introduction

Skin diseases represent one of the most frequent reasons for pediatric outpatient consultations, accounting for 6-24% of all visits to primary care and specialist services depending on geographic region and institutional setting. This disproportionate burden reflects the biological vulnerability of the immature pediatric integument - characterized by a thinner stratum corneum, higher transepidermal water loss relative to body surface area, and an incompletely calibrated innate and adaptive cutaneous immune response - which renders children particularly susceptible to infectious, inflammatory, and immune-mediated dermatoses during the first decade of life. The clinical picture is further complicated by the fact that several of these conditions present with morphologically similar primary lesions - erythema, vesiculation, scaling, and lichenification - in configurations that evolve with the child's age, making a diagnosis established in infancy potentially inappropriate at school age when the disease phenotype may have substantially shifted. Misdiagnosis in pediatric dermatology carries consequences beyond diagnostic accuracy: delayed treatment of scabies permits continued transmission within households, empirical corticosteroid therapy applied to unrecognized tinea corporis or scabies ("tinea incognita" and "scabies incognita") markedly alters lesion morphology and masks the clinical features on which subsequent diagnosis must rely, and unnecessary antibiotic or antifungal prescriptions contribute to resistance patterns in the community. A systematic, age-

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stratified approach to the clinical and differential diagnosis of the most common pediatric dermatoses is therefore not merely an academic exercise but a clinical necessity.

Literature Review

The epidemiological landscape of pediatric dermatoses was comprehensively mapped in a multicenter study by Sacchidanand et al. (2014), which recorded 1,118 dermatoses across 1,090 pediatric outpatients, identifying bacterial infections and scabies as the most prevalent conditions followed by molluscum contagiosum and atopic dermatitis, with childhood psoriasis constituting the majority of papulosquamous disorders. The global burden of pediatric atopic dermatitis was quantified using Global Burden of Disease 2021 data, which estimated 72.4 million affected children aged 0-14 worldwide - a 6.2% increase from 2000. The clinical and differential diagnostic challenges specific to pediatric AD were systematically reviewed by Cabanillas et al. (2022) according to PRISMA guidelines, incorporating 40 studies and providing the most structured diagnostic framework for distinguishing AD from its mimics in the 0-11 year age group. Impetigo epidemiology in children was addressed in a global systematic review by Bowen et al., which established a median childhood prevalence of 12.3% and estimated more than 162 million children affected at any given time. The seasonal variation, age distribution, and clinical patterns of the six most common under-five dermatoses were analyzed by Nanda et al. across 879 pediatric outpatients, providing granular epidemiological data on impetigo, miliaria, scabies, furunculosis, seborrheic dermatitis, and papular urticaria. Differential diagnosis of pruritic dermatoses in children was systematically reviewed by Ständer et al. (2021), establishing the evidence hierarchy for distinguishing primary inflammatory from infectious causes of pediatric pruritus.

Methodology

A structured narrative review was performed. Literature searches were conducted in PubMed/MEDLINE, Scopus, Web of Science, eLIBRARY.ru, and the Cochrane Skin Database, covering publications from January 2010 through April 2025. Priority was given to studies published after 2018. Search terms included: "pediatric dermatoses differential diagnosis," "atopic dermatitis children clinical features," "impetigo children epidemiology," "scabies pediatric diagnosis," "tinea corporis children dermoscopy," "pediatric psoriasis vs atopic dermatitis," "molluscum contagiosum children diagnosis," "seborrheic dermatitis infant diagnostic criteria," and "common skin diseases children prevalence." Inclusion criteria required studies to report original clinical data on dermatoses in patients aged 0-18 years, with explicit diagnostic criteria and quantifiable prevalence, incidence, or diagnostic accuracy metrics. The seven dermatoses selected for this review were chosen on the basis of three criteria: (1) documented prevalence exceeding 2% in pediatric dermatology outpatient populations in at least two independent international studies; (2) known propensity for diagnostic confusion with at least one other condition on this list; and (3) clinical significance of misdiagnosis in terms of patient harm or transmission risk. Selected conditions were: atopic dermatitis (AD), seborrheic dermatitis (SD), impetigo contagiosa, scabies, tinea corporis/capitis, psoriasis vulgaris, and molluscum contagiosum. Outcome parameters and diagnostic tools assessed. Clinical diagnosis was evaluated using the Hanifin and Rajka criteria for AD (requiring 3 of 4 major criteria and 3 of 23 minor criteria), the SCORAD index for severity quantification, and dermoscopic criteria where

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applicable. Laboratory tools assessed included: direct microscopy with 10% KOH preparation for fungal elements; mineral oil mount microscopy for Sarcoptes scabiei mites, eggs, and scybala; Tzanck smear and PCR for herpetic superinfection; bacterial culture and sensitivity for impetigo differentiation; patch testing for allergic contact dermatitis; and skin biopsy for diagnostically ambiguous cases.

Age-stratified diagnostic approach. Given the well-established phenotypic variation of several dermatoses by age, differential diagnostic algorithms were stratified into three groups: infant (0-2 years), childhood (2-12 years), and adolescence (12-18 years). This stratification is clinically validated by the finding that SCORAD scores correlate negatively with age at disease onset ($r = 0.474$, $p < 0.001$), confirming that clinical severity and diagnostic complexity are highest in the youngest age group.

Results

Epidemiology of common pediatric dermatoses. In the largest single-center pediatric dermatology dataset (n = 879 children under 5 years), the six most prevalent dermatoses were: impetigo (221 cases; 25.1%), miliaria (190 cases; 21.6%), scabies (148 cases; 16.8%), furunculosis (133 cases; 15.1%), seborrheic dermatitis (118 cases; 13.4%), and papular urticaria (94 cases; 10.7%). In a separate referral-center series of 5,250 pediatric patients encompassing all age groups, the most common diagnoses were: atopic dermatitis (14.59%), viral warts (6.62%), acne vulgaris (5.53%), pityriasis alba (3.98%), melanocytic nevi (3.85%), xerosis (3.57%), keratosis pilaris (3.19%), seborrheic dermatitis (2.37%), hemangioma (2.26%), and papular urticaria (2.24%). Global AD prevalence in children aged 0-14 reached 72.4 million cases in 2021, with regional prevalence ranging from 1.50% in Rwanda to 10.67% in Mongolia. Impetigo global childhood prevalence reached a median of 12.3% (IQR 4.2-19.4%), with the highest rates in underprivileged pediatric populations of high-income countries (median 19.4%).

Atopic dermatitis - clinical features and diagnostic criteria. AD in infancy (0-2 years) characteristically presents with exudative, intensely pruritic eczematous plaques distributed over the cheeks, forehead, and extensor surfaces of the extremities, with relative sparing of the diaper area. In the childhood phase (2-12 years), the distribution shifts to flexural folds - antecubital and popliteal fossae, wrists, and ankles - with lichenification emerging as the dominant morphological feature of chronic disease. Diagnosis requires fulfillment of the Hanifin and Rajka major criteria: (1) pruritus; (2) typical morphology and age-specific distribution; (3) chronic or relapsing course; (4) personal or family history of atopy. SCORAD scores in moderate-to-severe pediatric disease typically range from 33 to 44 in food-sensitized children versus 14-16 in non-sensitized patients ($p < 0.001$). Serum IgE levels correlate significantly with severity ($R = 0.31$, $p < 0.001$); 65.9% of pediatric AD patients demonstrate IgE values above age-adjusted norms, with a mean of 1,127 732 IU/mL. Seborrheic dermatitis - clinical features and differentiation. Infantile SD manifests within the first weeks of life as adherent, yellowish, greasy scales on the vertex scalp ("cradle cap"), with potential extension to the retroauricular folds, nasolabial folds, and flexures. Unlike AD, SD in infants resolves spontaneously in approximately 80-95% of cases before the second year of life and is notably non-pruritic, a critical distinguishing feature. Lesions in SD are uniformly distributed along sebaceous gland-rich zones, whereas AD lesional distribution in infants follows a centrifugal cheek-first pattern.

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When SD is accompanied by alopecia, tinea capitis must be excluded by KOH microscopy and fungal culture before treatment. Impetigo - clinical features and differentiation. Impetigo contagiosa, caused by Staphylococcus aureus (median culture positivity 64%, IQR 53-80%) and Streptococcus pyogenes (median 74%, IQR 57-95%), presents in two forms: non-bullous impetigo - honey-colored crusts overlying shallow erosions, most commonly on the lower extremities and face - and bullous impetigo - flaccid vesicles and bullae containing cloudy fluid, caused by exfoliative toxin-producing S. aureus phage group II. The lower extremities are the most commonly affected site in 91% of reported studies. In children with pre-existing AD, S. aureus superinfection (impetigo incognito) may present without the classical honey-colored crust because the underlying eczematous skin alters lesion morphology; bacterial culture from intact vesicle fluid or blister roof is diagnostic. Scabies - clinical features and differentiation. Scabies, caused by Sarcoptes scabiei var. hominis, produces a polymorphic eruption of papules, vesicles, and excoriated nodules with characteristic localization to interdigital spaces, wrists, axillae, umbilical region, and genitalia. In children, unlike adults, the scalp, face, palms, and soles are frequently involved - a distribution pattern overlapping significantly with AD. The pathognomonic burrow - a 2-10 mm linear or curved grayish track representing the female mite's tunnel - is best identified dermoscopically as the "jet with contrail" pattern. Confirmation requires mineral oil microscopy identifying mites, eggs (ovoid, 150 100 μm), or fecal pellets (scybala). Scabies itching is characteristically nocturnal and affects multiple household members simultaneously - the latter being the single most clinically useful epidemiological discriminator from AD. Scabies prevalence among the pediatric dermatoses studied was 16.8% (148/879 under-five patients), with significantly higher rates in winter ($p < 0.0001$, $\chi = 17.44$).

Tinea corporis and capitis - clinical features and differentiation. Tinea corporis classically presents as an erythematous, annular, scaly plaque with active, raised, vesicular borders and central resolution - the "ring worm" configuration. However, atypical morphology is not uncommon and may mimic nummular eczema, pityriasis rosea, or AD. Tinea capitis, caused by Trichophyton or Microsporum species, manifests as scaly scalp patches with associated alopecia, broken hair shafts ("black dot" sign), cervical lymphadenopathy, and occasionally a kerion - a boggy, inflammatory mass. KOH microscopy demonstrating branching hyphae confirms the diagnosis, though the presence of hyphae does not exclude concurrent AD. Culture on Sabouraud dextrose agar provides species identification and guides antifungal selection. Psoriasis - clinical features and differentiation. Pediatric psoriasis (PP) affects approximately 0.5-2% of children and is often misdiagnosed as AD because plaques in children are less thick, less white, and less well-demarcated than in adults. The most common childhood form is inverse psoriasis, affecting the diaper area and skin folds - closely mimicking seborrheic dermatitis and contact dermatitis. Nail involvement with fine pitting (as opposed to the coarser pitting of pachyonychia) is a subtle but diagnostically useful distinguishing feature of psoriasis from AD. Importantly, approximately 5% of the pediatric population has a confirmed overlap of both AD and psoriasis, requiring concurrent management of both inflammatory pathways. Psoriasis is particularly resistant to topical corticosteroid monotherapy, and persistence of treatment refractoriness in a child diagnosed with "eczema" should prompt reconsideration of this diagnosis. Molluscum contagiosum - clinical features and differentiation. Molluscum contagiosum, caused by Molluscipoxvirus, presents as 2-5 mm dome-shaped, pearly, umbilicated papules distributed on the trunk, axillae, and anogenital region. In children with AD, molluscum infection produces an

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eczematous reaction (molluscum dermatitis) in the surrounding skin that may be misattributed to an AD flare, delaying antiviral or physical treatment of the molluscum lesions themselves. Dermoscopy of molluscum reveals a pathognomonic "white or yellow amorphous lobular structure" surrounded by a crown of vessels, allowing confident differentiation from epidermal cysts, closed comedones, and viral warts without biopsy.

Discussion

The differential diagnostic challenge in pediatric dermatology is not merely academic. The consequences of misdiagnosis are concrete, frequent, and clinically serious. The single most instructive pattern emerging from the reviewed data is the frequency with which atopic dermatitis is used as a default diagnosis when a child presents with pruritus and erythematous skin lesions - and how often this default is incorrect. Scabies, in particular, is systematically underdiagnosed in children with pre-existing dermatitis, because the eczematous reaction to mite infestation morphologically resembles an AD flare. The telling epidemiological clue - multiple household members affected simultaneously with identical nocturnal pruritus - is not elicitable from the child directly and requires a structured family history, which is frequently not obtained in a busy outpatient setting. The clinical impact of applying topical corticosteroids to undiagnosed tinea corporis is a particularly instructive teaching case. Corticosteroid-modified tinea ("tinea incognita") loses its characteristic raised, scaly annular border and central clearing, presenting instead as a diffuse erythematous, minimally scaling patch that no longer resembles ringworm to the examining clinician. KOH microscopy is therefore not an optional confirmatory test but an essential first-line investigation when any scaling dermatosis fails to respond to first-line empirical therapy - a principle that applies equally to seborrheic dermatitis resistant to antifungal shampoo and to "eczema" resistant to topical corticosteroids.

Age-stratified diagnostic thinking is the most practical framework for organizing the differential in a clinical encounter. In the infant, the priority is distinguishing AD from SD - which rests almost entirely on pruritus (present in AD, absent in SD) and natural history (SD resolves before age 2, AD persists) - and from scabies, which in this age group involves the scalp and palms, zones spared by both AD and SD. In the school-age child, tinea corporis and nummular eczema join the differential for any isolated annular or coin-shaped lesion. In the adolescent, acne, psoriasis, and contact dermatitis become increasingly relevant as sebaceous activity and environmental exposures change. The integration of dermoscopy into routine pediatric dermatological assessment has meaningfully improved diagnostic accuracy for molluscum contagiosum (pathognomonic lobular structure with crown vessels), scabies (jet-with-contrail burrow sign), and tinea capitis (broken hair patterns), without requiring biopsy or significant patient discomfort - an especially important advantage when examining young children. Clinicians working in pediatric primary care and outpatient dermatology settings should consider basic dermoscopy training as a standard competency rather than a subspecialty skill.

Common pediatric dermatoses - AD, seborrheic dermatitis, impetigo, scabies, tinea, psoriasis, and molluscum contagiosum - share morphological features that mandate a structured, age-stratified differential diagnostic approach. Pruritus character, lesion distribution, household contact history, natural history, and targeted laboratory investigations (KOH microscopy, mineral oil mount, bacterial culture, dermoscopy) collectively enable accurate diagnosis and prevent the compounding harm of

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empirical therapy applied to the wrong condition. Impetigo and scabies, affecting up to 25.1% and 16.8% of under-five dermatology patients respectively, deserve priority in the differential of any pruritic or crusted childhood skin eruption in resource-limited or high-density living settings.

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