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THE MOST COMMON DERMATOLOGICAL CONDITIONS IN INFANTS IN PRIMARY CARE SETTINGS – A REVIEW

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ABSTRACT

Introduction: Dermatological conditions are among the most common health issues affecting infants. These include atopic dermatitis, seborrheic dermatitis, and diaper dermatitis. Most cases can be successfully treated by primary care physicians. However, if left untreated, they can lead to chronic skin problems, inflammation, superinfection, and systemic symptoms.
Study objective: The aim of this study is to analyze the prevalence of dermatological conditions within the infant population, identify the most frequently occurring disorders and evaluate current treatment approaches available in primary care settings, based on up-to-date medical evidence.
Materials and methods: A literature review was conducted using PubMed to collect all available and current medical knowledge regarding the most common dermatological conditions in infants.
Conclusions: Studies have shown that in dermatological diseases in infants proper skincare plays a major role as a preventative and as a treatment. Nevertheless, in some cases there is a need to use prescription remedies. Better education in newborns' parents can reduce occurrence of dermatological diseases such as atopic dermatitis, seborrheic dermatits and diaper dermatitis.

KEYWORDS

Infants, Newborns, Atopic Dermatitis, Seborrheic Dermatitis, Diaper Dermatitis

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1. Introduction

At the 30th Congress of the European Academy of Dermatology and Venerology in 2021, data revealed that nearly half of Europeans experienced skin problems within a year. This highlights the significant health and social impact of dermatological diseases. In the pediatric population especially, many diseases manifest through the skin. An infant's delicate skin is highly sensitive, making it particularly vulnerable to various conditions. The family physician's office is usually the first point of contact for concerned parents who notice something unusual on their child's skin. The most common dermatological disease is atopic dermatitis, diagnosed in around 5% of children in Poland (1) Other frequent conditions include seborrheic dermatitis, diaper dermatitis, skin infections, viral and contagious diseases, infantile and adolescent acne. This paper will discuss the three most common conditions.

2. Most Common Skin Problems in Children

2.1 Atopic Dermatitis

Atopic dermatitis (AD) affects around 15–20% of children globally, making it one of the most prevalent chronic inflammatory skin diseases in this population (2). It typically begins in early childhood. It is estimated that symptoms appear in 45% of children by six months of age and in 50% by one year. In 40–80% of cases, the disease tends to resolve before the age of five (3). AD is an allergic inflammatory skin condition characterized by a chronic and recurrent course. Diagnosis is based on the Hanifin and Rajka criteria (4). The four major criteria include pruritus, typical distribution of lesions, chronic or relapsing course, and personal or family history of atopy. Minor criteria include dry skin, elevated IgE levels, intolerance to wool or certain foods, recurrent skin infections, recurrent conjunctivitis, hand or foot eczema, cheilitis and pruritus after sweating. A patient must meet at least three major and three minor criteria (5).

In infants and children under two years, typical lesion locations include cheeks, hairy scalp, trunk and extensor surfaces of the limbs. In older children, the lesions typically occur on the face, neck and in flexural areas (elbows, neck) (6).

Intense itching is a key symptom, often causing irritability, crying, and sleeping difficulties. Most children with atopic dermatitis have difficulty falling asleep and sleeping through the night, leading to daytime sleepiness. (7). Regardless of age, the foundation of treatment is proper basic skin barrier therapy (8). Transepidermal water loss is increased in AD. Research shows, that the regular use of emollients in children with mild to moderate AD reduces the severity of symptoms and, therefore, support their use as a first-line treatment for these patients (9). Emollients are recommended 2–3 times daily. Recently, ”plus" emollients enriched with additional active ingredients like flavonoids, saponins, and bacterial lysates (e.g., *Aquaphilus dolomiae*, *Vitreoscilla filiformis*) are used for their anti-inflammatory and skin barrier-supporting properties (10). Appropriate topical treatment with emollients can lessen the need for anti-inflammatory drugs such as glucocorticosteroids or calcineurin inhibitors.

Major criteria (3 out of 4)	Minor criteria (3 or more)
• Pruritus • Typical morphology and distribution • Chronic or relapsing course • History of atopy	• Xerosis • Ichthyosis/palmar hyperlinearity/keratosis pilaris • Immediate (type I) skin test reactivity • Elevated serum IgE • Early age of onset • Tendency toward cutaneous infections (esp. Staphylococcus aureus and Herpes simplex)/impaired cell-mediated immunity • Tendency toward nonspecific hand or foot dermatitis • Nipple eczema • Cheilitis • Recurrent conjunctivitis • Dennie-Morgan infraorbital fold • Keratoconus • Anterior subcapsular cataracts • Orbital darkening • Facial pallor/facial erythema • Pityriasis alba • Anterior neck folds • Itch when sweating • Intolerance to wool and lipid solvents • Perifollicular accentuation • Food intolerance • Course influenced by environmental/emotional factors • White dermographism/delayed blanch

Atopic skin requires special care. Short baths using soap substitutes and immediate application of emollients afterward are advised.

Topical treatment of lesions typically involves corticosteroid ointments. Side effects must be considered, especially in young children, where overuse can lead to bacterial infections, skin atrophy, telangiectasia, systemic symptoms, growth inhibition, and osteoporosis. In newborns and infants, the use of topical corticosteroids (TCS) is contraindicated due to the risk of adverse effects. In children under 2 years of age, TCS may be used only when skin lesions do not respond to intensive emollient care. Application should be avoided on large skin areas, as well as the groin, skin folds, around the eyes, and the face.

It is recommended to apply TCS once daily for 3–5 days (11). Fluticasone 0.05% cream is approved for short-term use in children ≥3 months and mometasone cream and ointment are approved for children ≥2 years old. (6)

A safe alternative to topical steroids are calcineurin inhibitors – pimecrolimus and tacrolimus. Pimecrolimus, approved for children from the age of 2 with mild to moderate atopic dermatitis (AD), is also used in clinical practice in younger children – even from 3 months of age – due to its favorable safety profile. Their potency is comparable to medium-strength topical corticosteroids. These medications are especially recommended for use on sensitive areas such as the face, neck, skin folds and the diaper area.

A well-established method of applying TCIs is:

- application to affected areas twice daily until symptom resolution (but no longer than 6 weeks),
- followed by proactive therapy – twice weekly, once per day.

The most commonly observed side effect of TCI use is skin irritation, often accompanied by a burning sensation, which is why sun protection is recommended (12).

In severe or refractory cases, systemic therapy may include cyclosporine A, methotrexate, azathioprine, mycophenolate mofetil, systemic corticosteroids or phototherapy (3, 13, 14)

Chronic use of topical antibiotics is not recommended due to antibiotic resistance (15).

Primary prevention methods are also available for at-risk children (e.g., those with a positive family history), including prolonged breastfeeding, avoiding tobacco smoke during pregnancy, reducing allergen exposure, and using emollients from birth.

Parental cooperation is essential, making educational materials, campaigns and programs valuable for understanding the disease and its treatment principles.

2.2 Seborrheic Dermatitis

Another common dermatologic issue in infants, often considered in the differential diagnosis of atopic dermatitis, is seborrheic dermatitis (SD). Its incidence peaks around three months of age, reaching approximately 70%. Among infants younger than one month and children aged 1 to 2 years, its prevalence ranges between 7–10%, decreasing with age (16). SD usually appears earlier, between the 2nd and 10th week of life. The exact pathogenesis remains unclear. Factors include maternal androgens stimulating sebaceous glands, nutritional deficiencies, immunoincompetence, and overgrowth of *Malassezia* fungi, part of the skin's natural microbiota (17).

Lesions commonly affect the scalp—known as cradle cap—but can extend to other regions of the body. They present as gray-yellow greasy scales. Lesions can be found typically in areas dense in sebaceous gland activity, such as the scalp, eyebrows, glabella (the area between the eyebrows), nasolabial folds and postauricular area (18, 19). In the diaper area, infantile seborrheic dermatitis presents as a sharply demarcated, erythematous, greasy, scaly eeruption with a tendency to merge into larger confluent lesions. It may be mistaken for candidal dermatitis (19). As in AD, a weakened skin barrier can in some cases promote secondary bacterial and fungal infections. Itching is usually mild or absent.

Treatment focuses on proper care of affected areas. It consists primarily of emollients that help loosen scales (e.g., mineral or olive oil, petroleum jelly). Scales can then be removed with infant hair brush. Preparations containing salicylic acid or urea (lotions, oils, shampoos) can help remove scales. Antifungal agents, particularly 2% ketoconazole or zinc pirythione shampoo, are effective, used twice a day for 2 weeks (20, 21). If itching or erythema is significant, topical corticosteroids may be used. Suspected secondary infection warrants specific topical treatments (19, 22, 23). In mild cases, treatment may not be necessary—gentle hygiene and oiling the scalp may suffice. With appropriate care, symptoms generally resolve within a few weeks, although they may persist up to one year (24).

2.3 Diaper Dermatitis

Diaper dermatitis (DD) is another common condition in newborns and infants, with a reported prevalence ranging from 7% to over 40% (25). It is an inflammatory reaction in the diaper area, typically presenting as eczematous lesions with erythematous papules, vesicles, and erosions. It is often associated with *Candida* yeast infection. Candidiasis manifests as bright red lesions with satellite pustules, mainly in skin folds. It usually affects infants under 12 months (26).

The underlying causes include a moist environment, irritation from urine and stool, and inadequate hygiene. Risk factors include diarrhea, antibiotic therapy and infrequent diaper changes. Some studies suggest a link between the rise of disposable diapers, wipes, reduced breastfeeding, and increased incidence of diaper dermatitis.

Initial treatment focuses on proper hygiene: gentle cleansing and thorough drying of the area, avoiding synthetic materials, frequent diaper changes (every 2–4 hours) and allowing diaper-free time. Caretakers are also advised to avoid using disposable wet wipes. Sometimes, emollient therapy alone is sufficient. Topical skin barrier repair cosmetic products are the mainstay treatment to cure and/or prevent DD. Barrier creams based on zinc, panthenol and glycerin are commonly recommended (27). Pharmacological treatment should be tailored to the cause. Short-term use of mild corticosteroids or calcineurin inhibitors should be considered in some cases. Bacterial secondary infection requires topical antibiotics; fungal infection—nystatin or clotrimazole. If allergic contact dermatitis is suspected, hygiene products should be changed. Educating caregivers about potential allergens and irritants is a crucial part of prevention (28–30).

3. Conclusions

Dermatitis in infants is a common concern and often the first dermatological challenge in primary care. It is essential for physicians to accurately identify and manage skin conditions, but even more important is educating parents about proper skin care. The complexity of these conditions—stemming from both genetic and environmental factors—requires a holistic and individualized approach from the family physician. In more severe cases, referral to a dermatologist is advisable. There is a need to develop standardized treatment protocols and invest in educational tools to support both healthcare providers and caregivers in effectively managing these conditions.

Infant skin conditions can be a major source of stress for new parents, who worry about even minor issues. The primary role of the family physician in such situations is to reassure and educate caregivers, since appropriate skincare is the cornerstone of treatment for most common infant dermatological conditions. Still, when symptoms are severe, specialist consultation is necessary.

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