Skin eruptions tend to be particularly alarming to parents. The visible evidence of a change to a body part provokes anxiety in patients and parents alike, even if the afflicted is not feeling pain or discomfort. Pediatricians are at the front line of assessing these sudden rashes. When an eruption is widespread or unfamiliar, the physician too will feel anxious, and worry about the possibility of failing to consider a diagnosis he or she may not have previously encountered. Textbooks of dermatology are brimming with obscure and esoteric diagnoses, providing an intimidating breadth of knowledge even for those of us immersed in the study of the skin.

Physicians operate in fear of missing a critical diagnosis. We worry that we may have failed to consider the entity that will “crack the case.” Thus, familiarizing ourselves with a comprehensive array of possibilities is crucial, but this becomes increasingly difficult for the primary care physician faced with a myriad of complaints involving every organ system of the body. For many practitioners, this challenge is met by having a systematic approach to differential diagnosis. Within dermatology, that systematic approach can often be met by assessing the morphologic characteristics of a skin eruption and building one’s differential from that foundation.

In this issue of Pediatric Annals, four distinct morphologic patterns of skin eruptions are presented. An illustrative case is used to introduce each morphology, followed by an in-depth discussion of each diagnosis and a differential enumerating several key disorders that share the particular morphologic characteristic. Drs. Sarah L. McFarland and Ingrid C. Polcari introduce the reader to acneiform eruptions in children, and expand on the topics of acne in infants, perioral dermatitis, facial angiofibromas, childhood rosacea, and acneiform drug eruptions. Dr. Lacey L. Kruse provides an approach to linear eruptions of childhood, including acquired inflammatory eruptions such as lichen striatus, congenital linear lesions such as epidermal nevus, inflammatory linear verrucous epidermal nevus and nevus sebaceous, and exogenous triggers causing linear eruptions such as contact dermatitis and phytophotodermatitis. Dr. Patricia S. Todd and colleagues discuss annular eruptions. They explore the features that distinguish granuloma annulare, tinea corporis, annular urticaria, neonatal lupus erythematosus, erythema multiforme, and erythema chronicum migrans. Finally, Dr. Duri Yun and I review blistering conditions including those related to inflammatory triggers, infection, autoimmunity, and drugs.

It is my hope that these articles will provide an organized and accessible approach to formulating a logical and reasonable differential diagnosis when faced with what might at first seem to be a bizarre or alarming rash in a child.

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Sarah L. Stein, MD, is an Associate Professor of Medicine and Pediatrics at the University of Chicago Pritzker School of Medicine where she is the Director of Pediatric Dermatology and is the Program Director for the Dermatology Residency Program. She received her medical degree from the Albert Einstein College of Medicine in New York City, then went on to complete her pediatrics training at The Floating Hospital for Children at the New England Medical Center in Boston, followed by dermatology training at Northwestern University Feinberg School of Medicine.

Dr. Stein is an expert in the diagnosis and management of childhood skin diseases, including dermatitis of various types, pigmented disorders, birthmarks, disorders of hair and nails, infectious skin conditions, and cutaneous manifestations of internal diseases. She has a special interest in the presentation of skin disease in children of color. She believes that family education and support are fundamental in pediatric patient care.

Address correspondence to Sarah L. Stein, MD, via email: sstein@medicine.bsd.uchicago.edu.