SUMMARY AND CONCLUSION

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Vesicular, bullous and pustular lesions in the neonatal period, are common presentations to the pediatritian. These lesions may hide an underlying serious cause which may be life threatening.

This work was done in order to study carefully all cases of these lesions, in regard to their incidence, clinical manifestations, histopathological findings in some selected cases and the broad lines of diagnosis.

This study involved fifty neonatal cases of both sexes (35 males and 15 females). They were selected from the pediatric department and outpatient pediatric and dermatologic clinics of Zagazig University Hospitals.

All cases were subjected to full history including personal, present, past, family and dietary history as well as clinical examination. The laboratory investigations included staining for fungi by KOH stain, for bacteria by Gram stain and for white blood cells by Giemsa stain

as well as histopathological examination of 6 selected cases by Haematoxylin and eosin stain the clinical and laboratory investigations revealed

11 cases of miliaria (8 cases of miliaria crystallina and 3 cases of miliaria rubra).

9 cases of erythema toxicum neonatorum.

8 cases of candidiases.

6 cases of Periporitis staphylogens

5 cases of impetigo neonatorum.

5 cases of primary irritant contact dermatitis.

2 cases of acne neonatorum.

1 case of drug eruption.

1 case of sucking blister.

1 case of transient neonatal pustular melanosis.

From the above we can notice that some causes are dangerous and similar to the self-limiting ones.. Therefore, it is essential that every case of neonatal vesicular, bullous or pustular lesion must be examined carefuly, clinicaly and microscopically in order to reach to an acurate diagnosis so as to follow the appropriate lines of treatment.

Forty percent of our cases were due to infections. The bad hygenic conditions in our community may play an important rule in this respect. Improvement of the hygenic habits must be our aim.

Staphylococal infection was found in 3/4 of all infections, therefore, antistreptococcal antibiotics (e.g. methicillin, nafcillin, oxacillin and others). Must be the first choice for treating bacterial infections.

This study showed a high incidence of miliaria, the hot and humid weather in our country is a perpituating factor. Regulation of ambient temperature (if possible) often prevents miliaria and we advice to change frequently wet clothes.

This study showed a low incidence of erytheme toxicum neonatorum (18%), perhaps due to the low birth weight and the difficulty of recognition in non white neonates.

As for infection by candida albicans (congenital and neonatal), prophylaxis by treating the

infected pregnant women is very important especially if we know that intrauterin death or soon after labour may occur as acomplication of congenital type.

Ten percent of cases suffered from primary irritant contact dermaitis which is caused by prolonged contact between the delicate neonatal skin and irritants especially stool, urine, saliva and milk. Proper cleaning of the neonatal skin is essential. This needs educational programs for mothers to keep hygenic conditions.

In spite of the fact that epidermolysis bullosa is a rare condition and no case could be find in this study, a very simple test (Nikolysky's test) must be done to exclude it when suspected.

In cases of junctional epidermolysis bullosa, parents should be told that with each pregnancy there is a one in four chance that the child may be affected. This may be an indication for sterilization.

Cases of recessive dystrophic epidermolysis bullosa must be followed up, as oesophageal stricture and flexion contracture of joints may occur in childhood age.

The simplest method of preventing herpes infection in the neonate, of course, is to deliver all pregnant women with known genital herpes infection by casserian section. This approach is effective if the membrane is intact. In cases of suspected foetal infection, amnio centesis is helpful, if the virus is recovered from amniotic fluid, caeserian section is no longer beneficial.

In cases of pachyonychia congenita, oral leukokeratosis should be evaluated periodically, since malignant changes may occur as early as the 2nd decade of life.

Although transient neonatal pustular melanosis was first described by **Rammamurthy (1976)**, it is not a very rare disorder, as one case was found in this study.