In our series, all patients had quick good-quality remission with a median progression-free survival of 6 months. The rapidity of the response supports the role of vinblastine instead of spontaneous regression in these patients with multifocal lesions and a long-term history of refractory disease. In our series, no patient had to discontinue use of the drug because of infection or severe toxic effects.

Vinblastine should be studied in larger series to confirm its effectiveness and tolerance in disseminated or refractory CD30+ lymphomas. Its place as second-line treatment could be considered with failure of methotrexate and perhaps as first-line treatment in the case of contraindication to methotrexate, especially in older adults.

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OBSERVATION

Practical Events in the Management of a Collodion Baby

The term collodion baby (CB) refers to a newborn whose entire body is covered with an adherent, supple, parchment-like membrane.1 The condition is usually associated with ecchymosis, ecchymosma, hypotrichosis, hypoplastic nasal and auricular cartilage, and pseudocontractures. Collodion baby is a phenotype rather than a specific disease entity. The membrane eventually detaches in 3 to 4 weeks, usually revealing a permanent ichthyosis phenotype.

Due to the impaired barrier function of the CB’s skin, transepidermal water loss (TEWL) can be more than 6-fold greater than the TEWL of normal skin.2 Newborn CBs are at risk for hypernatremic dehydration, hypothermia, and infection. Promptly placing the baby in a humidified incubator, where the temperature-controlled, humidified environment greatly reduces TEWL, is considered essential.3 Clinical management also relies on daily bathing with water (with or without a mild cleanser) and frequent liberal applications of bland emollients, e.g., petrolatum.

Most researchers recommend setting the incubator’s humidity at 40% to 60%,4 although some advocate 90% to 100%.5 In addition, they recommend maintaining the child in the incubator for at least 4 weeks (or until the membrane completely detaches). These are not evidence-based incubator guidelines, and we believe that a CB’s transition from humidified incubators to open cribs may take place sooner than conventionally advised.

Report of a Case | We describe herein a newborn girl born at 39 weeks’ gestation to a 31-year-old healthy woman after an unremarkable pregnancy. A shiny, taut membrane covered her entire body (Figure), and further examination showed small, low-set ears appressed to the parietal scalp, mild ectropion and eclabium, and absent eyelashes and eyebrows. Because of increased TEWL, dehydration, hypernatremia, and decreased body temperature were of concern. Serum electrolytes, urine output, daily weights, albumin, blood urea nitrogen, and creatinine levels were monitored closely.

On day 2 of her life, our management departed from an unyieldingly strict regimen of confinement to the incubator by permitting 30-minute “holidays” outside the incubator.
roughly every 3.5 hours, to let the baby breastfeed and bond with her parents. Therefore, during each 24-hour period, she left the incubator 8 times, totaling 4 hours.

The baby gained weight (indicating adequate oral intake) and maintained normal body temperature and blood chemistry values. On day 12, we increased her daily time out of the incubator to 6 hours by increasing the duration of incubator holidays to 60 minutes each and decreasing the number of incubator holidays to 6 (Table). We decreased humidity by 10% per day from the incubator’s 60% to the ambient 20% of the neonatal intensive care unit over days 12 to 16. This was well tolerated, and the baby was discharged to home on day 16. Genetic tests showed that she had autosomal recessive congenital ichthyosis, lamellar type.

Discussion | This case shows that weaning medically stable CBs from the humidified incubator can begin early using a gradual, stepwise approach. In the present case, we began this process on day 2 of the baby’s life, and on day 12, we began incrementally reducing the incubator humidity to ambient levels. Although most CBs are not premature, a study of preterm infants showed that delayed transitions from incubator to open cribs are associated with delayed achievement of full-volume oral feedings, decreased growth velocity, and prolonged hospitalization.3 With a CB, the goals should be achieving temperature stability, maintaining fluid and electrolyte balance, transitioning to an open crib, and encouraging parental bonding. Temperature instability or fluid-electrolyte imbalance during this transition would require resuming management with the humidified incubator and thus delaying the transition to the open crib.

We report this observation to assist others who, while cognizant of published recommendations to maintain the child in 60% humidity for 3 to 4 weeks, wish to achieve the benefits of a more flexible CB protocol. With our patient, those benefits included early direct breastfeeding (rather than drinking pumped milk by bottle inside the incubator), early parental bonding, and early hospital discharge. Until there are evidence-based guidelines for CB management, we offer this more flexible CB protocol as an option and describe its benefits as well as its lack of harm.

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Oral Acyclovir and Intraleisional Interferon Injections for Treatment of Giant Pyogenic Granuloma–Like Lesions in an Immunocompromised Patient With Human Orf

Orf is a zoonotic infection caused by a parapoxvirus and is widespread in sheep and goats. Human orf, characterized by self-limiting purulent skin lesions at inoculation sites, is caused by contact with infected animals. In immunocompromised patients, orf often exhibits atypical, multifocal, persistent, giant lesions, making treatment frustrating.

Report of a Case | A man in his 40s presented with a 3-month history of 3 rapidly enlarging lesions that developed at the sites of injuries sustained while working with livestock. He had a history of transplantation 3 years earlier and had been taking...