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DHA TELEHEALTH CLINICAL GUIDELINES

FOR VIRTUAL MANAGEMENT

OF RASHES IN CHILDREN – 49

Issue date: 27/07/2021

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Health Policies and Standards Department

Health Regulation Sector (2021)

INTRODUCTION

Dubai Health Authority (DHA) is the responsible entity for regulating, licensing and monitoring health facilities and healthcare professionals in the Emirate of Dubai. The Health Regulation Sector (HRS) is an integral part of DHA and was founded to fulfil the following overarching strategic objectives:

Objective #1: Regulate the Health Sector and assure appropriate controls are in place for safe, effective and high-quality care.

Objective #2: Position Dubai as a global medical destination by introducing a value-based, comprehensive, integrated and high-quality service delivery system.

Objective #3: Direct resources to ensure happy, healthy and safe environment for Dubai population.

ACKNOWLEDGMENT

This document was developed for the Virtual Management of Rashes in Children in collaboration with Subject Matter Experts. The Health Policy and Standards Department would like to acknowledge and thank these professionals for their dedication toward improving the quality and safety of healthcare services.

The Health Regulation Sector

Dubai Health Authority

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EXECUTIVE SUMMARY

Telehealth is based on Evidence Based Practice (EBP) which is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence and guidelines from systematic research.

EBP is important because it aims to provide the most effective care virtually, with the aim of improving patient outcomes. As health professionals, part of providing a professional service is ensuring that practice is informed by the best available evidence.

This guideline is presented in the format comprising of clinical history/symptoms, differential diagnosis, investigations and management. Identification of 'Red Flags' or serious conditions associated with the disease is an essential part of this telehealth guideline as it aids the physician to manage patients safely and appropriately by referrals, if indicated during virtual telehealth assessment, to ER, family physicians or specialists for a face to face management.

The primary purpose of this Telehealth Guideline is to prove the health physicians, who will be managing patients virtually, with a summary of the best available evidence for the virtual management of this very common condition among adults.

This guideline also identifies key "Red Flags" or serious symptoms associated with Rashes in Children which warrant a referral to specialist for further face-to-face management.

DEFINITIONS/ABBREVIATIONS

Virtual Clinical Assessment: Is the evaluation of the patient's medical condition virtually via telephone or video call consultations, which may include one or more of the following: patient medical history, physical examination and diagnostic investigations.

Patient: The person who receives the healthcare services or the medical investigation or treatment provided by a DHA licensed healthcare professional.

ABBREVIATIONS

DHA	:	Dubai Health Authority
EBP	:	Evidence Based Practice
ER	:	Emergency Room
KPI	:	Key Performance Indicator

1. BACKGROUND

1.1. Introduction

1.1.1. The word "rash" means a change in the color and texture of skin that usually causes an outbreak of red patches or bumps on the skin. In common usage of the term, a "rash" can refer to many different skin conditions. A rash can be caused, directly or indirectly, by a bacterial, viral, fungal infection or causes.

2. SCOPE

2.1. Telehealth services in DHA licensed Health Facilities.

3. PURPOSE

3.1. To support the implementation of Telehealth services for children with Rashes in Dubai Health Authority (DHA) licensed Health Facilities

4. APPLICABILITY

4.1. DHA licensed physicians and health facilities providing Telehealth services.

4.2. Exclusion for Telehealth services are as follows

4.2.1. Emergency cases where immediate intervention or referral is required.

4.2.2. Prescribe Narcotics, Controlled or Semi-Controlled medications.

5. CAUSES

5.1. Rash with fever

5.1.1. Slapped cheek syndrome/ Erythema infectiosum/ Fifth disease

5.1.2. Hand, foot and mouth disease

5.1.3. Scarlet fever

5.1.4. Measles

5.2. Rash with itching

5.2.1. Heat rash/ Prickly heat

5.2.2. Eczema

5.2.3. Urticaria/ Hives

5.2.4. Tinea/ ringworm

5.2.5. Chickenpox

5.2.6. Impetigo

5.2.7. Scabies

5.3. Rash without fever or itching

5.3.1. Milia

5.3.2. Erythema toxicum

5.3.3. Molluscum contagiosum

5.3.4. Diaper dermatitis/ Nappy rash

5.3.5. Baby acne

5.3.6. Cradle cap

5.3.7. Oral candidiasis

6. ASSESSMENT

6.1. For an accurate assessment of the condition, it is necessary perform clinical examination through either:

6.1.1. Video consultation

6.1.2. High resolution photographs

6.2. History

6.2.1. The presence or absence of associated symptoms can help clinicians develop a differential diagnosis. The most important initial questions to ask the parents calling for a child with a skin problem include the following:

a. How long has the eruption or lesion been present?

b. How did it look when it first appeared, and how is it now different?

c. Where did it first appear, and where is it now?

d. What associated symptoms, such as itching, stinging, tenderness, or pain, are associated with the lesion?

e. Are any other family members affected or have a similar history?

f. Has the child ever had this rash or lesion before? If so, what treatment was used, and what was the response?

g. What does the parent think cause the rash or lesion?

h. Is anything new or different (e.g., medications, personal care products)?

i. How does the skin problem impact the child?

j. What treatments have been used, and what was the response, this time and previously?

6.3. Additional questions that may be helpful include:

6.3.1. Does the child have any acute or chronic medical conditions?

6.3.2. What medications does the child take currently, what have they recently taken, including over-the-counter and herbal therapies?

6.3.3. Is there a family history of skin disorders or skin cancer?

6.3.4. What is the social history, including travel?

6.3.5. Does the child have any allergies?

6.3.6. Are there pets at home?

7. RASH WITH FEVER

7.1. Slapped cheek syndrome/ fifth disease/ erythema infectiosum

7.1.1. Erythema infectiosum, or fifth disease, is caused by parvovirus B19. It is a common childhood infection characterized by a prodrome of low-grade fever, malaise, sore throat, headache, and nausea followed several days later by an erythematous “slapped cheek” facial rash. After 2 to 4 days, the facial rash fades. In the second stage of the disease process, pink

patches and macules may develop in a lacy, reticular pattern, most often on the extremities. After 1 to 6 weeks, the rash resolves but may reappear with sun exposure, heat, or stress. Arthralgias occur in approximately 8% of young children with the disease but are much more common in teens and young adults. Patients are no longer considered infectious once the rash appears.

7.1.2. Treatment:

a. Rest

b. Fluids

c. Pain relievers (do not give aspirin to children). Paracetamol can bring down a fever.

7.2. Hand- foot- mouth disease

7.2.1. Caused by the Coksackie Virus, this is a common childhood illness. It is a contagious infection that starts with a fever, followed by painful mouth sores and

a non-itchy rash. The rash blisters on hands, feet, and sometimes buttocks and legs. It's most common in young children (particularly those under 10 years), but it can also affect older children and adults. It spreads through coughing, sneezing, and used diapers. So, wash hands often. Coxsackie usually goes away on its own in about a week.

7.3. Treatment:

7.3.1. Plenty of fluids

7.3.2. If eating and swallowing is uncomfortable, soft foods such as mashed potatoes, yoghurt and soup can be given.

7.4. Scarlet fever

7.4.1. Scarlet fever is diagnosed in 10% of children presenting with streptococcal tonsillopharyngitis. It is caused by certain strains of group A beta-hemolytic streptococci that release a streptococcal pyrogenic exotoxin (erythrogenic toxin). Patients who have a hypersensitivity to the toxin may develop the characteristic rash

associated with scarlet fever. Most children have a fever and sore throat 1 to 2 days before the rash develops on the upper trunk. The rash spreads throughout the body, sparing the palms and soles, with characteristic circumoral pallor. This differs from some viral exanthems that develop more slowly. The rash is characterized by confluent, erythematous, blanching, fine macules, resembling a sunburn, and sandpaper-like papules. In skinfolds, such as the axilla, antecubital fossa, and buttock creases, an erythematous, non-blanching linear eruption (Pastia lines) may develop. Petechiae on the palate may occur, as well as erythematous, swollen papillae with a white coating on the tongue (white strawberry tongue). Red strawberry tongue occurs after desquamation of the white coating. After several weeks, the rash fades and is followed by desquamation of the skin, especially on the face, in skin-folds, and on the hands and feet, potentially lasting 4 to 6 weeks.

7.4.2. Investigation

If further investigations are required for establishing a diagnosis, then a referral to “face to face” consultation is advised for investigations such as

a. Throat culture for diagnosis of group A streptococcal infection
b. Rapid antigen tests

7.4.3. Treatment

a. Penicillin is the therapy of choice for streptococcal infection

   Children ≤27 kg: 250 mg 2 to 3 times daily for 10 days

   Children >27 kg and Adolescents: 500 mg 2 to 3 times daily for 10 days;

b. Those allergic to penicillin and cephalosporins may be treated with oral macrolides

   Clindamycin – oral 3–6 mg/kg 4 times a day (max. per dose 450 mg) for 10 days.

   Clarithromycin - 7.5 mg/kg/dose twice daily (max = 250 mg/dose for 10 days

   Azithromycin - oral 12 mg/kg once daily (max = 500 mg) for 5 days

7.5. Measles

7.5.1. Measles most commonly affects young children. It's now rare because of the effectiveness of the measles, mumps and rubella (MMR) vaccine. The

measles rash is red-brown blotches. It usually starts on the head or upper neck and then spreads outwards to the rest of the body. They may also have a fever and cold-like symptoms. Measles usually passes in about seven to 10 days without causing further problems.

7.5.2. Treatment: Measles usually passes in about 7 to 10 days without causing further problems. Paracetamol or ibuprofen can be used to relieve fever and aches. The child should be made to drink plenty of water to avoid dehydration.

8. RASH WITH ITCHING

8.1. Prickly heat (heat rash)

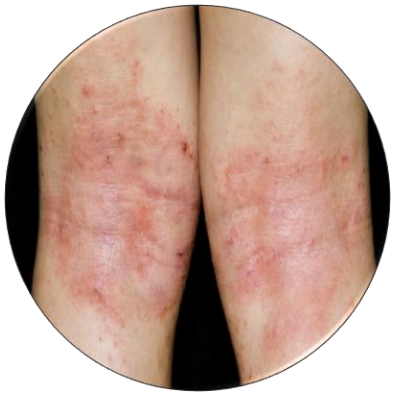
8.1.1. Prickly heat (heat rash), also known as miliaria presents as itchy rash of small, raised red spots that causes a stinging or prickly sensation on the skin. It occurs when the sweat ducts in the outer layer of skin (epidermis) are obstructed. Heat rash anywhere on the body, but the face, neck, back, chest or thighs are most often affected. Infants can

sometimes get a prickly heat rash if they sweat more than usual – for example, when it's hot and humid or if they're overdressed.

8.1.2. Treatment: It rarely requires any specific treatment.

8.2. Eczema

8.2.1. The most common type eczema is atopic eczema, which mainly affects children but can continue into adulthood. Atopic eczema commonly develops behind the knees or on the elbows, neck, eyes and ears. The severity of atopic eczema can vary a lot from person to person. Mild eczema may only have small areas of dry skin that are occasionally itchy. In more severe cases, atopic eczema can cause widespread red, inflamed skin all over the body and with constant itching. Though it isn't a serious condition, but if the child later becomes infected with the herpes simplex virus, it can cause the eczema to flare up into an outbreak of tiny blisters called eczema herpeticum and will cause a fever.



8.2.2. Treatment: There is no cure for atopic eczema, but treatments can ease the symptoms. Many children find their symptoms naturally improve as they get older. The main treatments for atopic eczema are:

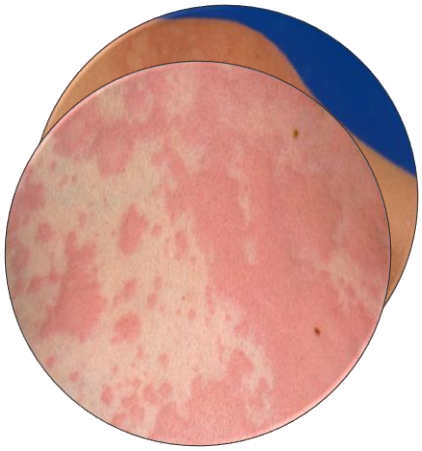
a. Emollients (moisturisers) like Vaseline petrolatum jelly – used every day to stop the skin becoming dry

b. Topical corticosteroids – Hydrocortisone 1%, Clobetasone butyrate 0.05%, Betamethasone dipropionate 0.05% creams and ointments for 7 to 14 days used to reduce swelling and redness during flare-ups

c. Other treatments include

- Topical pimecrolimus twice daily application or tacrolimus 0.03% ointment twice daily (not suitable for less than 2 years) for eczema in sensitive sites not responding to simpler treatment
- Antihistamines – e.g.: Cetirizine 2.5 mg (0.5 teaspoon) oral solution PO qDay; can increase to 5 mg PO qDay or 2.5 mg PO twice daily; not to exceed 5 mg qDay.
- <2 years: Safety and efficacy not established
- Bandages or special body suits to allow the body to heal underneath, or more powerful treatments offered by a dermatologist.

8.3. Urticaria (hives)



8.3.1. Urticaria also known as hives, wheals, welts or nettle rash – is a raised, itchy rash that can affect one part of the body or be spread across large areas. It's a common skin reaction that often affects children. There are many possible triggers of urticaria, including allergens, such as food or latex, irritants, such as nettles, medicines, and physical factors, such as heat or exercise. Sometimes, a cause can't be identified.

8.3.2. Treatment: The rash is usually short-lived and mild, and can often be controlled with antihistamines.

8.3.3. Cetirizine

a. Infants 6 to <12 months: 2.5 mg once daily

b. Children 12 to 23 months: Initial: 2.5 mg once daily; dosage may be increased to 2.5 mg twice daily

c. Children 2 to 5 years: Initial: 2.5 mg once daily; dosage may be increased to 2.5 mg twice daily or 5 mg once daily; maximum daily dose: 5 mg/day

8.4. Tinea Capitis/Ringworm

8.4.1. Tinea capitis is characterized by scaling or circumscribed alopecia and broken hair follicles.

8.4.2. Posterior cervical lymphadenopathy is another useful finding to distinguish tinea capitis from other causes of alopecia. This can be understood by requesting the child's parent to palpate around the neck/ jaw areas and look for swelling/ tenderness which can be demonstrated through video consultation.

8.4.3. The characteristic lesion found in children with tinea corporis is an erythematous annular patch or plaque with a raised border and central clearing; scaling along the border is common. This lesion is often referred to as Ringworm.

8.4.4. Treatment: Ringworm can usually be easily treated with antifungal medicines. Ringworm of the scalp can cause scaling and patches of hair loss. It's treated with antifungal tablets, often combined with antifungal shampoo.

8.4.5. Treatment of Tinea Capitis is:

a. Terbinafine:

b. Doses: ≥4 years (<25 kg): 125 mg/day PO for 6 weeks

c. ≥4 years (25-35 kg): 187.5 mg/day PO for 6 weeks

d. ≥4 years (>35 kg): 250 mg/day PO for 6 weeks

8.4.6. Antifungal shampoo.

8.5. Chickenpox

8.5.1. Chickenpox is a viral illness that most children catch at some point. It most commonly affects children under 10 years of age. It is self-limiting.

8.5.2. A rash of itchy spots turns into fluid-filled blisters. They crust over to form scabs, which after a while drop off. Some children only have a few spots, whereas others have them over their entire body. The spots are most likely to appear on the face, ears and scalp, under the arms, on the chest and belly, and on the arms and legs.

8.5.3. Treatment: If the child is in pain or has a high temperature (fever), painkiller, such as paracetamol can be given. It is important for children with chickenpox to drink plenty of water to avoid dehydration. Avoid anything that may make the mouth sore, such as salty foods. Chickenpox can be incredibly itchy, but it's important for children to not scratch the spots, to avoid future scarring. One way of stopping scratching is to keep fingernails clean and short. try using calamine lotion or cooling gels. Chlorphenamine can also help to relieve the itching.

8.6. Impetigo

8.6.1. Impetigo is a primary or secondary bacterial infection of the epidermis of the skin. Primary infections occur when bacteria enter breaks in the skin, whereas secondary infections develop at the site of an existing dermatosis. There are bullous and non-bullous forms of the infection, with the bullous form typically occurring in neonates and the non-bullous form most common in preschool- and school-aged children. Although Streptococcus pyogenes was once the most common cause of non-bullous impetigo, Staphylococcus aureus has surpassed it in more recent years. However,

S. pyogenes may still be the predominant cause in warm and humid climates. S. aureus is the main source of bullous impetigo. Initially, children may develop vesicles or pustules that form a thick, yellow crust. With autoinoculation, the lesions may quickly spread. The face and extremities are most commonly affected. Although impetigo is usually a self-limited disease, antibiotics are often prescribed to prevent complications and spread of the infection.

8.6.2. Treatment: Although impetigo is usually a self-limited disease, antibiotics in the form of topical or oral may be given.

8.6.3. Topical:

a. Mupirocin 2% cream TID for 7 to 10 days

b. Bactroban TID for 7 to 14 days

c. Fusidic acid TID for 7 to 12 days

8.6.4. Oral:

a. Augmentin syrup

b. 25 mg/kg/day in divided doses twice daily

8.7. Scabies

8.7.1. Scabies is a contagious skin condition that's intensely itchy. It's caused by tiny mites that burrow into the skin.

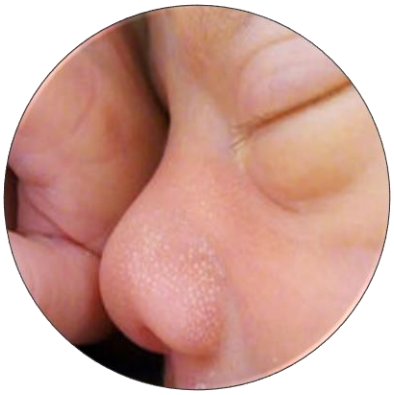
8.7.2. Typical cutaneous findings are multiple small, erythematous papules, often excoriated. Burrows may be visible as 2 to 15 mm, thin, gray, red, or brown, serpiginous line. Burrows are a characteristic finding but often are not visible due to excoriation or secondary infection. Miniature wheals, vesicles, pustules, and, rarely, bullae also may be present.

8.7.3. In children, scabies is usually spread through prolonged periods of skin-to-skin contact with an infected adult or child – for example, during play fighting or hugging. The mites like warm places, such as skin folds, between the fingers, under fingernails, or around the buttock creases. They leave small red blotches, which are often found on the palms of the hands or soles of the feet. In infants, blisters are commonly found on the soles of the feet.

8.7.4. Treatment: Everyone in the household needs to be treated at the same time – even if they don't have symptoms. Treatment is two applications, 1 week apart, of 5% Permethrin cream to the whole body, to be washed off after 8 to 12 hours.

9. RASH WITH ITCHING

9.1. Milia



9.1.1. Milia are small epidermal cysts that develop from pilosebaceous follicles. They present as asymptomatic, firm, white or cream-colored papules, 1-2mm in diameter. They may be single or multiple and occur on the face. They occur frequently in the newborn and in infancy, but usually disappear within a few weeks of birth.

9.1.2. Treatment: There is no treatment needed as it is self-limiting.

9.2. Erythema Toxicum Neonatorum

9.2.1. Erythema toxicum neonatorum (ETN) is a common pustular disorder occurring in approximately 20% of neonates in the first 72 hours of life. It occurs more frequently in neonates with higher birthweight and greater gestational age. The etiology is unknown.

9.2.2. ETN presents with multiple erythematous macules and papules (1 to 3 mm in diameter) that rapidly progress to pustules on an erythematous base. The lesions are distributed over the trunk and proximal extremities, sparing the palms and soles. They may be present at birth but typically appear within 24 to 48 hours. The rash usually resolves in 5 to 7 days, although it may wax and wane before complete resolution. The diagnosis is usually made based on the clinical appearance. If the presentation is atypical, referral for face to face consultation is advised and cultures of the pustule contents for bacteria, fungi, and viruses should be obtained; these are all negative in ETN.

9.2.3. Treatment: ETN resolves spontaneously. No treatment is necessary.

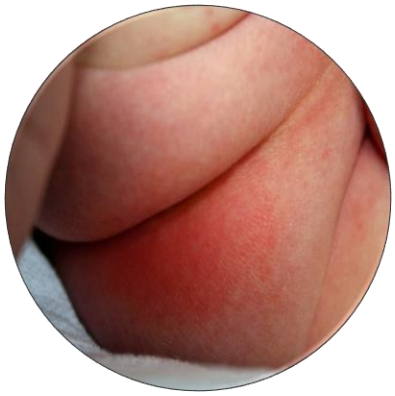
9.3. Molluscum Contagiosum

9.3.1. Molluscum contagiosum is a skin infection caused by a poxvirus. This highly contagious viral infection most commonly affects children 2 to 11 years of age. It also occurs in sexually active adolescents. The lesions are flesh-colored or pearly white, small papules with central umbilication. The oral mucosa is rarely affected, but lesions may appear on the genital region and conjunctiva. Typically, children have 10 to 20 lesions, but occasionally there may be up to hundreds. Molluscum may also occur in conjunction with dermatitis. It can erupt and spread quickly in a child with underlying atopic dermatitis, or it can induce dermatitis in a child with previously clear skin (molluscum dermatitis).

9.3.2. The diagnosis of molluscum contagiosum is made clinically.

9.3.3. Treatment: The condition is self-limited, but clinicians should advise parents to use gentle skin care products on the patient and that lesions may last for months or up to 2 to 4 years. Treatment options, including cryotherapy, imiquimod and intralesional immunotherapy, are available if physical appearance is a concern. These will require a face to face consultation with a specialist dermatologist.

9.4. Diaper Dermatitis/Nappy Rash



9.4.1. Diaper dermatitis, also called diaper rash, napkin dermatitis, and nappy rash, is the most common skin eruption in infants and toddlers. It typically occurs on convex skin surfaces that are in direct contact with the diaper, including the buttocks, lower abdomen, genitalia, and upper thighs. The severity of irritant diaper dermatitis ranges from mild asymptomatic erythema to severe inflammation.

9.4.2. A variety of factors may increase the risk of diaper dermatitis:

a. Infants with diarrhea or chronic stooling have an increased risk of developing diaper dermatitis due to continuous local skin irritation.

b. Dietary factors also may play a role. Breast-fed infants have a lower incidence of diaper dermatitis than formula-fed infants, possibly because breast-fed infants have lower stool PH.

c. Recent use of broad-spectrum antibiotics may predispose infants to develop diaper dermatitis by increasing the risk of developing diarrhea and secondary yeast infections.

9.4.3. The course of diaper dermatitis is typically episodic. Each episode of mild to moderate diaper dermatitis treated with conventional therapies has an average duration of 2 to 3 days. Diaper dermatitis that persists for more than 3 days despite standard treatment may be secondarily infected with Candida albicans. The diagnosis of irritant diaper dermatitis is made clinically, based upon the presence of an erythematous eruption that involves the convex surfaces of buttocks and genital area. The sparing of the skin folds is characteristic of irritant diaper dermatitis, unless there is Candida superinfection.

9.4.4. Treatment: In most cases, the management of diaper dermatitis involves general skin care measures e.g.

a. Frequent diaper changing, air exposure, gentle cleansing

b. Choice of diapers, and use of topical barrier preparations like zinc oxide ointment, powder or cream- to be used on clean area during diaper change

c. Low-potency topical corticosteroids and antifungals - nystatin, clotrimazole, miconazole, ketoconazole may be used after each diaper change for 4 to 7 days in severe cases and in cases complicated by Candida superinfection.

9.5. Baby Acne

9.5.1. It typically presents at 3 to 4 months of age but may rarely occur in the first few weeks of life. It results from hyperplasia of sebaceous glands secondary to androgenic stimulation and is more common in boys. It consists of typical acneiform lesions, including comedones, inflammatory papules, pustules, and, sometimes, nodules on the face. It usually clears spontaneously by late in the first year of life but may persist until 3 years of age. Treatment may be required because infantile acne can persist and occasionally cause scarring. Severe, unremitting infantile acne

may warrant evaluation for underlying androgen excess due to congenital adrenal hyperplasia, a gonadal or adrenal tumor, or precocious puberty. Some patients have recurrence of severe acne at puberty.

9.5.2. Treatment

a. Mild to moderate inflammation - mild keratolytic agents, such as benzoyl peroxide (2.5%), topical antibiotics (e.g., clindamycin or erythromycin), or topical retinoids may be used

b. Severe inflammation - systemic therapy with oral erythromycin, trimethoprim-sulfamethoxazole, or oral isotretinoin may be indicated. This will require a referral to the specialist.

9.6. Cradle Cap

9.6.1. The most common manifestation of seborrheic dermatitis in newborns and infants is "cradle cap," an asymptomatic and non-inflammatory accumulation of yellowish, greasy scales on the scalp. The vertex and the frontal area are commonly involved. Sometimes the eruption starts on the face, with erythematous, scaly, salmon-colored plaques. The forehead, the retroauricular areas, eyebrows and eyelids, cheeks, and nasolabial folds are commonly affected

9.6.2. The infant is generally well; feeding and sleep are not disturbed. The pruritus is mild in most cases. The clinical manifestations fluctuate, but most cases eventually resolve spontaneously within weeks to a few months. Cases persisting beyond the age of 12 months are rare and require the diagnosis to be reconsidered.

9.6.3. Treatment: In infants, seborrheic dermatitis has a self-limited course and resolves spontaneously in weeks to several months.

a. Initial treatment should be conservative, including education and reassurance of parents, and simple skin care measures.

b. Conservative measures for scalp seborrheic dermatitis may include:

- Application of an emollient (white petrolatum, vegetable oil, mineral oil, baby oil) to the scalp (overnight, if necessary) to loosen the scales, followed by removal of scales with a soft brush (e.g., a soft toothbrush) or fine-tooth comb.
- Frequent shampooing with mild, non-medicated baby shampoo followed by removal of scales with a soft brush (e.g., a soft toothbrush) or fine-tooth comb.

9.6.4. In more extensive or persistent cases, either a short course of low-potency topical corticosteroids applied once per day for 1 week or ketoconazole 2% cream or shampoo twice per week for 2 weeks. Corticosteroids are preferred if there is a predominant inflammatory component; ketoconazole 2% cream or shampoo is an alternative in diffuse cases or if the use of topical corticosteroids is a concern for the parents.

10. REFERRAL CRITERIA

10.1. Referral to Emergency Department

10.1.1. Referral to the Emergency Department must be done if the child is having a rash and they:

a. Have a stiff neck

b. Photophobia

c. Seem confused

10.2. Refer to Family Physician or Specialist

10.2.1. Persistent rash, not improving with medications

10.2.2. Recurrent rash

10.2.3. Have a fever that cannot be controlled

10.2.4. Past history of febrile convulsion

10.2.5. Immunocompromised

10.2.6. Needs further assessment or investigation

10.2.7. Diagnosis is uncertain

11. MANAGEMENT OF RASHES IN CHILDREN

11.1. Refer to APPENDIX 1 for the Virtual Management of Rashes in Children Algorithm

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APPENDIX 1 – VIRTUAL MANAGEMENT OF RASHES IN CHILDREN ALGORITHM