**PROFILE OF THE ETIOLOGICAL GROUPS OF THE DERMATOSES OF THE CHILD AT THE KINSHASA UNIVERSITY CLINIC - DEMOCRATIC REPUBLIC OF THE CONGO**

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**Summary  
Context and objectives**: The dermatoses of the child are a frequent reason for consultation in sub-Saharan Africa and in the Democratic Republic of the Congo in particular. The objective of this study is to determine the profile of dermatoses in children according to the etiological approach in the dermatology department of university clinics in Kinshasa.

**Methods**: In an analytical and descriptive study, the data of children with dermatitis, followed in the dermatology department of the University Clinics of Kinshasa between June 1, 2009 and December 31, 2011, were collected. The variables studied were epidemiological and clinical (clinical diagnoses)

**Results**: The incidence of dermatoses in children in hospitals was 40.89% (818/1994). Their median age was 60 months (EIQ 60-65.9) with a female predominance (55.7%, sex ratio of 1.25 / 1). The 0-2 age group was predominant (30.6%). Dermatosis in children predominated in the dry season (54%); the most frequent were infectious (40.0%, p = 0.023) and immunoallergic (33.4%, p = 0.043) with impetigo (18.7%) and atopic dermatitis (33.3 %) respectively as the main diagnosis.

**Conclusion**: Dermatosis in children is the exclusive preserve of infants; controllable causes, mainly infectious and immunoallergic. A healthy environment and a healthy lifestyle are to be promoted in our environment.  
**Keywords**: Epidemiology, Dermatosis, Child, University Clinics of Kinshasa.

**Introduction**Pediatric dermatology is a relatively recent sub-specialty and requires studies in our sub-Saharan and Congolese milieu in particular. There are dermatoses specific to the pediatric population and some clinical pictures, although found in adults, have some peculiarities. Like many diseases, children's dermatoses should be considered as a real public health problem in developing countries. They constitute nearly 30% of general consultations in dermatology [1,2,3]. However, they are demeurent little explored epidemiologically and clinically in the Democratic Republic of Congo (DRC) [4]. Generally, the diagnosis of dermatosis is based on the Willanist approach, which is based on the type of elementary lesion [5], an adequate process for the learner in dermatology; and / or depending on the etiology thereof. The latter method is easy and regular for the well-trained dermatologist. Each of these methods has its advantages and limitations [5]. Pediatric dermatoses constitute a set of pathologies of the skin and appendages, affecting the child, whose etiologies are varied immunoallergic, metabolic, infectious, genetic.

The epidemiology of pediatric dermatoses is a set of considerations around frequencies related to variables of interest including age, gender, season, socio-economic level, .... Its context may vary from one continent, one country or even one city to another, depending on the lesional and etiological approaches.  
Based on our previous article on the diagnostic lesional approach of childhood dermatoses [4], using the same database for the same study site, we thought it would be more appropriate to approach the same subject this time. under the diagnostic etiological approach.  
The frequencies of the dermatoses of the child are variously noted by the authors: 30% in tropical Africa [6], of which 23 - 33% in West Africa [7-9] and 40% in Africa [10].

**Aim and objectives of the work**  
Our goal, at the same time main objective, is to determine the incidence of the dermatoses of the child in tertiary hospital environment taking into account the etiological diagnostic approach and some epidemiological data, with a view to a better taking into account charge, from generalist to specialist, without relentlessness or therapeutic error that often lead to disastrous complications in the long term.  
**Methods**  
Study Framework: Our study was conducted in the Dermatology Department of Kinshasa University Clinics (CUK), a tertiary-level facility located in the Mount Amba district of Lemba Commune in the Democratic Republic of Congo.  
**Type and duration of the study**: This was an analytical and descriptive study, based on the records of children aged 0 to 18, admitted and examined for service for 31 months, from June 1, 2009, to December 31, 2011.

**Study Population and Sample**: Of a total of 1994 patients seen in the CUK Dermatology Department, 818 were children. Included in this study were all children aged 0 to 18 years, received and examined during the study period, whose medical records contained variables relevant to the study, with the informed consent of the grand child and / or parents ( or guardians) for the youngest children. Children over the age of 18 were not included in the study, or children aged at the specified age but whose medical records were incomplete in relation to the variables sought and informed consent.  
**Variables studied**: The variables studied were epidemiological (age, sex, month of the year and season at admission) and clinical (clinical diagnoses). The age was broken down as follows: 0-2 years (infants), 3-5 years (preschool age), 6-12 years (school age) and 13-18 years (adolescence). The season was attributed in dry (March, June, July and August) and rainy (January, February, April, May, September, October, November and December) periods [11]. The diagnosis was based on the clinic alone for most children.  
**Operational Definitions**  
Etiological group: group of dermatoses sharing the same family of pathogens (viruses, bacteria, fungi, parasites).

**Technical methods and data collection instruments**The information relevant to the study was collected from the registers and consultation forms, which were then recorded on our data collection forms developed for this purpose, containing all of our study variables. A compilation of these data was done at the end to identify, group and analyze all these variables of interest. All analyzes were performed using the SPSS (Statistical package for social sciences, Chicago) software for Windows version 21. Statistical data processing consisted of calculating the means, standard deviation, median and interquartile range for quantitative variables and proportions for qualitative variables. The Chi square test was applied to compare the proportions at the significance level p ˂0.05.  
**Ethical considerations**

Only records containing the informed consent of older children or parents (or guardians) for younger children were included in the study. The photos were taken at the time of the clinical examination, face veiled with respect for the confidentiality of the patient and his parents or guardians.  
Results  
**1- Epidemiological data**Our study population (818 children out of a total of 1994 patients) accounted for nearly 41% (40.89%); the female sex was predominant at 55.7% with a sex ratio between men and women of 1.25. Their median age was 60 months (EIQ 60 - 65.9 months), with extremes ranging from 0 to 218 months. The 0-2 age group was predominant (30.6%). The dermatoses of the child predominated in the dry season (54%), with peaks in February (12.3%), July (11.9%) and March (10.8%). The annual frequency of dermato-pediatric consultations ranged between 37 - 40%.

**2- Clinical data**  
According to Table II, the distribution of etiological groups of dermatoses by sex showed that infectious (40.0%) and immuno-allergic (33.4%) were the most frequent with predominance in the male sex ( 44.5%, p = 0.023) and female (36.4%, p = 0.048). Tumor dermatoses were more prevalent in girls (5.7%, p = 0.038).  
The distribution of the etiological groups of dermatoses according to the age groups in Table III showed that adnexal dermatoses were mainly found in infants (13.6%) and adolescents (19.4%) in a statistically significant way ( p = 0.001).  
The distribution of the etiological groups according to the seasons (Table IV) showed that the toxidermies were the most frequently encountered in the dry season in a statistically significant manner (p = 0.045).

In terms of frequencies, the distribution of the etiological groups of children's dermatoses showed that atopic dermatitis (33.3%) and prurigo strophulus (32.6%) were the most frequent in the group of immuno-allergic dermatoses. ; impetigo (18.7%), tinea capitis (16.8%) and scabiosis (16.2%) in the infectious group; sudamina (56.8%) in the adnexal; vitiligo (51.0%) inflammatory; ichthyosis vulgaris (30.4%) in genodermatoses; maculopapular erythema (61.5%) in toxidermias; hypertrophic scars (42.9%) and infantile haemangiomas (40.0%) in tumors.  
The distribution of dermatoses by etiological group versus age showed that most immunoallergic dermatoses were observed at all ages. However, statistically significant values ​​were noted for atopic dermatitis in school-age (50.0%, p = 0.001), prurigo strophulus between 0 - 5 years (32.0 - 48.3%, p = 0.005 urticaria in adolescence (42.1%, p <0.001), diaper rash in W (22.3%, p = 0.001) and contact dermatitis (15.8%, p = 0.005). ), respectively in infants and adolescents. For impetigo (43.2%) and tinea capitis (33.7%), infectious dermatosis was reported in the infant and the school-age group, respectively (p <0.001); while Gibert pink pityriasis (21.5%) and common warts (16.9%) were more common in adolescents, p <0.001. Sudamina and acne vulgaris were the most common adnexal dermatoses, respectively between 0 - 5 years (p <0.001) and 13 - 18 years (p = 0.002). The most common inflammatory dermatoses were vitiligo (0-2 years) and lichen planus (6-12 years), p <0.05. Tumor dermatosis with hypertrophic scars and infantile haemangiomas was more frequent at school-age (80%) and infants (72.2%), respectively, statistically significantly (p <0.05).  
The most frequent diagnoses of the child's dermatoses according to the etiological approach are shown in Table VII, at the top of which predominated atopic dermatitis, prurigo strophulus and impetigo.  
Of the 60 dermatoses diagnosed and seasonally aligned, Table VIII found higher frequencies for atopic dermatitis (13.1%) prurigo strophulus (8.8%), tinea capitis (8.1%) and scabiosis (6.6%). Overall, the occurrence of these dermatoses was not related to the season. However, impetigo (11.7%), sudamina (7.7%) and crawling myiasis (2.1%) were more observed in the rainy season, whereas hypertrophic scars (2.9%) predominated in the rainy season. dry season ; on both sides, the difference was statistically significant (p <0.05).

**DiscussionEpidemiological data**  
The aim of our study was to determine the incidence of child dermatosis (ED) in tertiary hospital according to the etiological approach, and in a complementary way to our previous study, which was based on the lesional diagnostic approach [4].  
In this work, our frequency of ED was 40.89%, which is in line with several studies conducted in Yemen 45.1% [12], Iran 43.9% [13] and Egypt 40% [ 14]; unlike the results of Fofana et al (31.51% [7], Mahé et al (32.9% [8], Traore et al (26.1%) [9] and Olusola et al 23.6% [15]). Females predominated, as opposed to some authors who found a predominance of men [7, 15], and infants were more numerous (30.6%, followed by adolescents (26.3%). is consistent with that of Semikenke et al in eastern DRC [10], but diverges from that of Osolula et al [15], Sardana et al [17], Tamer et al [18], Flavia et al [19]. , Anand et al [20] and Shibeshi et al. [21] who have a predominance of school-aged children, female dominance may be consistent with demographic realities, and our high frequency of ED may poor, socio-economically and sanitary precarious living conditions [22], main characteristics of the people living on the borders of CUK, but also the fact of being only medical facility in the tertiary level.

The dry season was the preserve of EDs (54%), with high peaks during the months of February (12.3%), July (11.9%) and March (10.8%). We agree with Emine et al, who report a predominance of ED in winter [16], but differ from El Khateeb et al [22] and Kamkimel et al [23] who find recurrence of these ED in summer. In our environment, the dry season is characterized by a dry and cold climate, a condition which does not always motivate the respect of hygiene rules, particularly the daily body bath, which favors xerosis of the skin. This abnormal condition of the skin is subject to pruritus and scratching, during which there may be skin rashes that may promote or maintain skin infections.  
**Clinical data**  
In our study, infectious (40%) and immunoallergic (33.4%) dermatoses were predominantly statistically significant (p <0.05, Table II). Comparable results have been reported by several authors for infectious [7, 15, 20, 22 - 27]. Casanova et al found a predominance of tumor dermatoses [28], unlike immunoallergic dermatoses, which returned to eastern DRC [10] and Brazil respectively [19]. For our study, the high frequency of infectious dermatoses, considered as dermatoses of the poor economy [29], could be explained by the promiscuity in which our general population lives, the deficient hygiene, the lack of environmental sanitation, ignorance of the first managers of these children and malnutrition [7, 15]. The majority of girls, however, had immunoallergic dermatoses (36%, p = 0.048), with atopic dermatitis being the most representative (33.3%) in both seasons with no statistically significant difference (Tables IV-V). with Malian [7], Nigerian [15], Brazilian [19], Indian [20], Russian [30], and Congolese [10] authors for atopic dermatitis as leader of immunoallergic dermatoses, unlike El Khateeb and al [22], Kramkimel et al [23] and Casanova et al [28] who report respectively a high frequency of contact eczema, urticaria and nonspecific eczema.  
The high incidence of atopic dermatitis in our study is the result of progressive urbanization and pollution of major cities such as Kinshasa, dry xerosis in the dry period and / or hyperhydration of the skin in the rainy season; this high frequency could also be linked to the fact that most children admitted to a specialized consultation are first treated by non-dermatologists who have given them inappropriate or even irritating treatments for already weakened skin [31, 32]. The literature in our possession is rather a predominance of autoimmune dermatoses in the female sex [33]. Our finding can be traced to demographic statistics where girls outnumber boys [34].

Most frequently observed infectious dermatoses (Table VI), impetigo (43.2%), and tinea capitis (33.7%) were most common between 0-2 years and 6-12 years of age (p <0.001), on the other hand, viral dermatoses such as Gibert's pityriasis rosé (21.5%) and common warts (16.9%) were more observed in adolescents (p inf 0.001). For impetigo, we agree with many authors [16, 22, 35], unlike Fofana et al. [10] who reported tinea capitis as the most common infectious dermatosis. The recurrence of impetigo in infants is due to infected sudamina, immaturity of the immune system [36] and conditions likely to favor infections as described above.  
With regard to tinea capitis during the school-age period, in addition to defective hygiene, interhuman contact, interchangeability of hats, combs and clippers during hair styling could justify this high frequency [16, 36 - 39]. We are in the same vein as Seudjip et al [40] for the pink pityriasis of Gibert. Efstratios et al [41] and Tamer et al [18] found a prevalence of common warts respectively between 6-12 years for some, 3 - 5 years and 12 - 16 years for others. With the different age groups that are close, growth period and hyperactivity of children at this time of their lives, the high frequency of these diseases at these ages can find an explanation.

Tumor dermatoses (Table II) were confined to females (5.7%), with hypertrophic scars (42.9%), followed by infantile hemangioma (40%) (Table V), pre-school age (80%) and infants (VI), regardless of the season (IV). For Casanova et al. [28] Tumor dermatoses were the most common (27.7%) with predominance of infantile hemangioma. The preponderance of hypertrophic scars, which are generally consistent with burns in our study, is a logical consequence of the use of traditional ovens often within the reach of children due to a lack of regular electricity supply in households.  
Adnexal dermatitis alone was statistically significant (p = 0.001) in infants (13.6%) and adolescents (19.4%), Table III, with 100% sudamina and 87.5% acne respectively. vulgar (table IV). We are in the same vein as Tamer et al [18] for both dermatoses. The tropical climate, hot and humid in the rainy season in our subregion, the way children sweat by mothers, the high transpiration could corroborate the high frequency of sudamina between 0-2 years [4]. Acne vulgaris goes hand in hand with the hormonal outbreak at the age of puberty generally corresponding to adolescence [5].

Seasonally (Table IV), toxidermia occurred at all times with high peaks in the dry season. This dry and cold period in Kinshasa is characterized by an upsurge of high and low respiratory diseases [42], often motivating self-medication based on sulfonamides, nonsteroidal anti-inflammatory drugs, drugs known to have side effects [43] .  
Vitiligo was the most observed inflammatory dermatitis (51%), Table V and especially in infants (P <0.001), Table VI. This contrasts with the results found by Fofana et al. [7] which highlighted a predominance of palmoplantar keratoderma as the first inflammatory dermatitis, as well as Olusola et al [15] for the age group (38% between 6-12 years). Parents' fear of macules evolving from hypochromia to achromia on the skin of their children, usually peri-orificial in areas of microtrauma [44], uncovered or not, could justify the early use of medical advice. specialized compared to adults who would have them on the genitals.  
Our findings for atopic dermatitis and prurigo strophulus are in line with Malian and Beninese studies [7, 45]. The high frequency of prurigo strophulus was found in Nigeria, 10.2% [15], unlike Indian values ​​5.2% [46] and Tanzania 5.6% [27]. Our finding could be explained by insect bites on the exposed parts of the body, the wearing of non-covering clothing, the stagnation of water in the uncured canivaux of our cities and promiscuity in addition to the hot and humid climate [7]. , 15].  
**Conclusion**The dermatoses of the child are frequent in our environment as evidenced by our results; the predominance of infectious and immuno-allergic, controllable, should motivate new vocations in pediatric dermatology and the promotion of good habits of  
  life, health and sanitation of the environment.

**List of tables**  
Table I. Epidemiological data

|  |  |  |
| --- | --- | --- |
| Variables | n=818 | Percentage |
| Sex |  |  |
| Masculin | 362 | 44,3 |
| Féminin | 456 | **55,7** |
| Age |  |  |
| 0-2 ans | 250 | **30,6** |
| 3-5 ans | 188 | 23,0 |
| 6-12 ans | 215 | 26,3 |
| 13-18 ans | 165 | 20,2 |
| Saeson |  |  |
| Dry | 442 | **54,0** |
| Rainy | 376 | 46,0 |
| Month of admission |  |  |
| January | 153 | 6,5 |
| February | 101 | **12,3** |
| March | 88 | **10,8** |
| April | 70 | 8,6 |
| May | 55 | 6,7 |
| June | 55 | 6,7 |
| July | 97 | **11,9** |
| August | 77 | 9,4 |
| September | 68 | 8,3 |
| October | 31 | 3,8 |
| November | 51 | 6,2 |
| December | 72 | 8,8 |
| Year of admission |  |  |
| 2009 | 189 | 23,1 |
| 2010 | 304 | 37,2 |
| 2011 | 325 | 39,7 |

Table II. Distribution of etiological groups of dermatoses by sex

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type de dermatose | All  n=818 | Male  n=362 | Female  n=456 | P |
| Infectious dermatosis | 327 (40,0) | 161 (44,5) | 166 (36,4) | **0,023** |
| Immuno-allergic dermatosis | 273 (33,4) | 107 (29,6) | 166 (36,4) | **0,048** |
| Adnexal dermatosis | 81 (9,9) | 42 (11,6) | 39 (8,6) | 0,191 |
| Inflammatory dermatosis | 49 (6,0) | 20 (5,5) | 29 (6,4) | 0,697 |
| Tumoral dermatosis | 35 (4,3) | 9 (2,5) | 26 (5,7) | **0,038** |
| Genodermatosis | 23 (2,8) | 7 (1,9) | 16 (3,5) | 0,244 |
| Toxidermy | 13 (1,6) | 7 (1,9) | 6 (1,3) | 0,687 |
| Unclassified dermatosis | 10 (1,2) | 5 (1,4) | 5 (1,1) | 0,946 |
| Dyschromic dermatosis | 7 (0,9) | 4 (1,1) | 3 (0,7) | 0,817 |

Table III. Distribution of etiological groups according to age

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type of dermatosis | 0-2 ans  n=250 | 3-5 ans  n=188 | 6-12 ans  n=215 | 13-18 ans  n=165 | P |
| Immuno-allergic dermatosis | 103 (41,2) | 60 (31,9) | 72 (33,5) | 38 (23,0) | 0,166 |
| Infectioud dermatosis | 81 (32,4) | 92 (48,9) | 89 (41,4) | 65 (39,4) | 0,302 |
| Adnexal dermatosis | **34 (13,6)** | 9 (4,8) | 6 (2,8) | **32 (19,4)** | **0,001** |
| Inflammatory dermatosis | 4 (1,6) | 8 (4,3) | 22 (10,2) | 15 (9,1) | 0,067 |
| Genodermatosis | 4 (1,6) | 7 (3,7) | 6 (2,8) | 6 (3,6) | 0,838 |
| Toxidermy | 3 (1,2) | 4 (2,1) | 3 (1,4) | 3 (1,8) | 0,934 |
| Dyschromic dermatosis | 0 (0,0) | 2 (1,1) | 3 (1,4) | 2 (1,2) | 0,998 |
| Tumoral dermatosis | 18 (7,2) | 5 (2,7) | 10 (4,7) | 2 (1,2) | 0,172 |
| Unclassified dermatosis | 3 (1,2) | 1 (0,5) | 4 (1,9) | 2 (1,2) | 0,896 |

Table IV. Distribution of etiological groups according to the seasons

|  |  |  |  |
| --- | --- | --- | --- |
| Type of dermatosis | Dry season=442 | Rainy season=376 | P |
| Immuno-allergic dermatosis | 150 (33,9) | 123 (32,7) | 0,773 |
| Infectious dermatosis | 170 (38,5) | 157 (41,8) | 0,374 |
| Adnexal dermatosis | 36 (8,1) | 45 (12,0) | 0,081 |
| Inflammatory dermatosis | 30 (6,8) | 19 (5,1) | 0,384 |
| Genodermatosis | 15 (3,4) | 8 (2,1) | 0,363 |
| Toxidermy | 11 (2,5) | 2 (0,5) | **0,045** |
| Dyschromic dermatosis | 2 (0,5) | 5 (1,3) | 0,395 |
| Tumoral dermatosis | 24 (5,4) | 11 (2,9) | 0,111 |
| Unclassified dermatosis | 4 (0,9) | 6 (1,6) | 0,556 |

Table V. Different frequencies of dermatoses by etiological groups

|  |  |  |
| --- | --- | --- |
| Varieties of Dermatoses | n | % |
| **Immunoallergic dermatosis** | **273** | **33,4** |
| Atopic dermatitis | 91 | 33,3 |
| Prurigo strophulus | 89 | 32,6 |
| Urticaria | 28 | 10,3 |
| Diaper rash in W | 24 | 8,8 |
| Eczématide | 23 | 8,4 |
| Contact derontmatitis | 17 | 6,2 |
| Photodermatosis | 1 | 0,4 |
| **Infectious dermatosise** | **327** | **40,0** |
| Impetigo | 61 | 18,7 |
| Tinea capitis | 55 | 16,8 |
| Scabiosa | 53 | 16,2 |
| Pityriasis rosea ofGibert | 34 | 10,4 |
| Tinea corporis | 26 | 8,0 |
| Vulgar wart | 17 | 5,2 |
| Seborrheic dermatitis | 12 | 3,7 |
| Pytiriasis versicolor | 10 | 3,1 |
| Myase rampante | 9 | 2,8 |
| Folliculitis | 9 | 2,8 |
| Molluscum contagesum | 8 | 2,4 |
| Diaper rash in Y | 7 | 2,1 |
| Varicella | 6 | 1,8 |
| Herpes | 5 | 1,5 |
| Onychomycosis | 3 | 0,9 |
| Zona | 2 | 0,6 |
| Anogenital condylome | 2 | 0,6 |
| Gonorrhea | 2 | 0,6 |
| Furonculoïd myiasis | 1 | 0,3 |
| Tungiasis | 1 | 0,3 |
| Measles | 1 | 0,3 |
| Oral condyloma | 1 | 0,3 |
| Meadow | 1 | 0,3 |
| Erysipela | 1 | 0,3 |
| **Adnexal dermatosis** | **81** | **9,9** |
| Sudamina | 46 | 56,8 |
| Acne vulgaris | 31 | 38,3 |
| Ongle incarnée | 4 | 4,9 |
| **Dermatose inflammatoire** | **49** | **6,0** |
| Vitiligo | 25 | 51,0 |
| Lichen planus | 7 | 14,3 |
| Erythema multiform | 5 | 10,2 |
| Psoriasis | 4 | 8,2 |
| Granuloma annulare | 3 | 6,1 |
| Pelad | 3 | 6,1 |
| Scléroderma | 1 | 2,0 |
| Erythema nodosum | 1 | 2,0 |
| **Génodermatosis** | **23** | **2,8** |
| Ichtyosis vulgaris | 7 | 30,4 |
| Keratosis pilairis | 4 | 17,4 |
| Hereditary epidermolysis bullosa | 3 | 13,0 |
| Verruciform epidermodysplasia | 2 | 8,7 |
| Palmoplantar kératodermae | 2 | 8,7 |
| Neurofibromatosis | 2 | 8,7 |
| Pityriasis rubra pilaris | 1 | 4,3 |
| Mosaicïsm | 1 | 4,3 |
| Baby collodion | 1 | 4,3 |
| **Toxidermia** | **13** | **1,6** |
| Maculopapular exanthema | 8 | 61,5 |
| Fixed pigmented erythema | 5 | 38,5 |
| **Dyschromic dermatosis** | **7** | **0,9** |
| Post inflammatory hyperpigmentation | 7 | 100,0 |
| **Dermatose tumorale** | **35** | **4,3** |
| Hypertrophic scar | 15 | 42,9 |
| Infant hemangioma | 14 | 40,0 |
| Warty nevus | 3 | 8,6 |
| Kaposi disease | 2 | 5,7 |
| Botriomycoma | 1 | 2,9 |
| Unclassified dermatosis |  |  |
| To determine | 10 | 100,0 |

Table VI. Distribution of dermatoses by etiological groups versus age

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Dermatosis | 0-2 years | 3-5 years | 6-12 years | 13-18 years | p |
| Immuno-allergic dermatosis |  |  |  |  |  |
| Atopic dermatitis | 30 (29,1) | 19 (31,7) | **36 (50,0)** | 6 (15,8) | **0,001** |
| Prurigo strophulus | **33 (32,0)** | **29 (48,3)** | 19 (26,4) | 8 (21,1) | **0,005** |
| Urticaria | 1 (1,0) | 3 (5,0) | 8 (11,1) | **16 (42,1)** | **<0,001** |
| Diaper rash in W | **23 (22,3)** | 1 (1,7) | 0 (0,0) | 0 (0,0) | **0,001** |
| Eczematide | 14 (13,6) | 4 (6,7) | 4 (5,6) | 1 (2,6) | 0,034 |
| Contact dermatitis | 2 (1,9) | 4 (6,7) | 5 (6,9) | **6 (15,8)** | **0,005** |
| Photodermatosis | 0 (0,0) | 0 (0,0) | 0 (0,0) | 1 (2,6) | - |
| Infectious dermatosis |  |  |  |  |  |
| Impetigo | **35 (43,2)** | 18 (19,6) | 7 (7,9) | 1 (1,5) | **<0,001** |
| Tinea capitis | 3 (3,7) | 21 (22,8) | **30 (33,7)** | 1 (1,5) | **<0,001** |
| Scabiosa | 9 (11,1) | 15 (16,3) | 20 (22,5) | 9 (13,8) | 0,181 |
| Pityriasis rosea of Gibert | 1 (1,2) | 7 (7,6) | 12 (13,5) | **14 (21,5)** | **<0,001** |
| Tinea corporis | 4 (4,9) | 10 (10,9) | 8 (9,0) | 4 (6,2) | 0,402 |
| Vulgar wart | 1 (1,2) | 4 (4,3) | 1 (1,1) | **11 (16,9)** | **<0,001** |
| Seborrheic dermatitis | 6 (7,4) | 0 (0,0) | 1 (1,1) | 5 (7,7) | 0,068 |
| Pytiriasis versicolor | 0 (0,0) | 0 (0,0) | 0 (0,0) | 10 (15,4) | - |
| Larva migrans | 3 (3,7) | 5 (5,4) | 1 (1,1) | 0 (0,0) | 0,273 |
| Folliculitis | 2 (2,5) | 4 (4,3) | 2 (2,2) | 1 (1,5) | 0,801 |
| Molluscum contagiosum | 2 (2,5) | 4 (4,3) | 2 (2,2) | 0 (0,0) | 0,717 |
| Diaper rash in Y | 6 (7,4) | 1 (1,1) | 0 (0,0) | 0 (0,0) | - |
| Varicella | 3 (3,7) | 0 (0,0) | 2 (2,2) | 1 (1,5) | - |
| Herpes | 1 (1,2) | 3 (3,3) | 0 (0,0) | 1 (1,5) | - |
| Onychomycosis | 0 (0,0) | 0 (0,0) | 1 (1,1) | 2 (3,1) | - |
| Zona | 0 (0,0) | 0 (0,0) | 0 (0,0) | 2 (3,1) | - |
| Anogénital condyloma | 2 (2,5) | 0 (0,0) | 0 (0,0) | 0 (0,0) | - |
| Gonorrhea | 0 (0,0) | 0 (0,0) | 0 (0,0) | 2 (3,1) | - |
| Furonculoïd miyasis | 1 (1,2) | 0 (0,0) | 0 (0,0) | 0 (0,0) | - |
| Tungiasis | 1 (1,2) | 0 (0,0) | 0 (0,0) | 0 (0,0) | - |
| Measles | 1 (1,2) | 0 (0,0) | 0 (0,0) | 0 (0,0) | - |
| Oral condyloma | 0 (0,0) | 0 (0,0) | 1 (1,1) | 0 (0,0) | - |
| Meadow | 0 (0,0) | 0 ( 0,0) | 0 (0,0) | 1 (1,5) | - |
| Erysipela | 0 (0,0) | 0 (0,0) | 1 (1,1) | 0 (0,0) | - |
| Adnexal dermatosis |  |  |  |  |  |
| Sudamina | **34(100,0)** | **8 (88,9)** | 3 (50,0) | 1 (3,1) | **<0,001** |
| Acne vulgaris | 0 (0,0) | 0 (0,0) | 3 (50,0) | **28 (87,5)** | **0,002** |
| Nail incarnated | 0 (0,0) | 1 (11,1) | 0 (0,0) | 3 (9,4) | - |
| Inflammatory dermatosis |  |  |  |  |  |
| Vitiligo | **4 (100,0)** | 5 (62,5) | 8 (36,4) | 8 (53,3) | **<0,001** |
| Lichen planus | 0 (0,0) | 0 (0,0) | 6 (27,3) | 1 (6,7) | **0,001** |
| Erythema multiform | 0 (0,0) | 0 (0,0) | 3 (13,6) | 2 (13,3) | - |
| Psoriasis | 0 (0,0) | 0 (0,0) | 3 (13,6) | 1 (6,7) | - |
| Granuloma annulare | 0 (0,0) | 3 (37,5) | 0 (0,0) | 0 (0,0) | - |
| Pelad | 0 (0,0) | 0 (0,0) | 2 (9,1) | 1 (6,7) | - |
| Scléroderma | 0 (0,0) | 0 (0,0) | 0 (0,0) | 1 (6,7) | - |
| Erythema nodosum | 0 (0,0) | 0 (0,0) | 0 (0,0) | 1 (6,7) | - |
| Genodermatosis |  |  |  |  |  |
| Ichtyosis vulgaris | 0 (0,0) | 1 (14,3) | 4 (66,7) | 2 (33,3) | - |
| Kératosis pilaris | 0 (0,0) | 4 (57,1) | 0 (0,0) | 0 (0,0) | - |
| Hereditary epidermolysis bullosa | 3 (75,0) | 0 (0,0) | 0 (0,0) | 0 (0,0) | - |
| Verruciform epidermodysplasia | 0 (0,0) | 1 (14,3) | 0 (0,0) | 1 (16,7) | - |
| Neurofibromatosis | 0 (0,0) | 0 (0,0) | 1 (16,7) | 1 (16,7) | - |
| Palmoplantar keratoderma | 0 (0,0) | 0 (0,0) | 0 (0,0) | 2 (33,3) | - |
| Piryriasis rubra pilaris | 0 (0,0) | 0 (0,0) | 1 (16,7) | 0 (0,0) | - |
| Mosaïcism | 0 (0,0) | 1 (14,3) | 0 (0,0) | 0 (0,0) | - |
| Baby collodion | 1 (25,0) | 0 (0,0) | 0 (0,0) | 0 (0,0) | - |
| Toxidermia |  |  |  |  |  |
| Fixed pigmented erythema | 2 (66,7) | 1 (25,0) | 1 (33,3) | 1 (33,3) | - |
| other toxidermia | 1 (33,3) | 3 (75,0) | 2 (66,7) | 2 (66,7) | - |
| Tumoral dermatosis |  |  |  |  |  |
| Hypertrophic scar | 4 (22,2) | 4 (80,0) | 6 (60,0) | 1 (50,0) | **<0,001** |
| Infant hemangiome | 13 (72,2) | 0 (0,0) | 1 (10,0) | 0 (0,0) | **<0,001** |
| Warty nevus | 0 (0,0) | 1 (20,0) | 2 (20,0) | 0 (0,0) | - |
| Kaposi disease | 1 (5,6) | 0 (0,0) | 1 (10,0) | 0 (0,0) | - |
| Botriomycoma | 0 (0,0) | 0 (0,0) | 0 (0,0) | 1 (50,0) | - |

Table VII. Most frequent diagnoses of children's dermatoses

|  |  |
| --- | --- |
| **Dermatoses** | **n (%)** |
| Atopic dermatitis | (91) 11,1 |
| Prurigo strophulus | (89) 10,9 |
| Impetigo | (61) 7,5 |
| Tinea capitis | (55) 6,7 |
| Scabiosa | (53) 6,5 |
| Sudamina | (53) 5,6 |
| Pityriasis rosea of Gibert | (34) 4,2 |
| Acne vulgaris | (31) 3,8 |
| Urticaria | (28) 3,4 |
| Tinea corporis | (26) 3,2 |

Tableau VIII. Distribution of the different etiological diagnoses according to the seasons

|  |  |  |  |
| --- | --- | --- | --- |
| Dermatosis | Dry season  n=442 | Rainy season  n=376 | P |
| Atopic dermatitis | 58 (13,1) | 33 (8,8) | 0,066 |
| Prurigo strophulus | 39 (8,8) | 50 (13,3) | 0,051 |
| Impétigo | 17 (3,8) | **44 (11,7)** | **<0,001** |
| Tinea capitis | 36 (8,1) | 19 (5,1) | 0,117 |
| Scabiosa | 29 (6,6) | 24 (6,4) | 0,979 |
| Sudamina | 17 (3,8) | **29 (7,7)** | **0,023** |
| Pityriasis rosea of Gibert | 18 (4,1) | 16 (4,3) | 0,974 |
| Acné vulgaris | 18 (4,1) | 13 (3,5) | 0,793 |
| Urticaria | 17 (3,8) | 11 (2,9) | 0,606 |
| Tinea corporis | 14 (3,2) | 12 (3,2) | 0,964 |
| Vitiligo | 16 (3,6) | 9 (2,4) | 0,429 |
| Diaper rash in W | 9 (2,0) | 15 (4,0) | 0,138 |
| Eczematide | 17 (3,8) | 6 (1,6) | 0,091 |
| Contact dermatits | 9 (2,0) | 8 (2,1) | 0,883 |
| Vulgar wart | 11 (2,5) | 6 (1,6) | 0,514 |
| Hypertrophic scar | **13 (2,9)** | 2 (0,5) | **0,021** |
| Infant hemangioma | 8 (1,8) | 6 (1,6) | 0,960 |
| Seborrheic dermatitise | 4 (0,9) | 8 (2,1) | 0,256 |
| To determine | 4 (0,9) | 6 (1,6) | 0,556 |
| Pytiriasis versicolor | 7 (1,6) | 3 (0,8) | 0,474 |
| Larva migrans | 1 (0,2) | **8 (2,1)** | **0,022** |
| Folliculitis | 6 (1,4) | 3 (0,8) | 0,632 |
| Other toxidermia | 7 (1,6) | 1 (0,3) | 0,132 |
| Molluscum contagiosum | 6 (1,4) | 2 (0,5) | 0,346 |

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