Collodion baby: A report of 4 cases

Abstract Introduction: The term collodion baby refers to a clinical entity noted in newborns who are enmeshed by a translucent, cornified substance like sheets of uniform texture so called (collodion membrane) which gives the whole body surface a varnished appearance. Although, some other diseases and conditions may lead to collodion membrane formation, in almost all the cases the cause is an autosomal recessive ichthyosiform disease.

Case Presentation: The first three cases are all from a consanguinely married couple of Fulani decent. The abnormal appearances of the babies’ skin were all noticed at birth. Parents are first cousins. The last case is a female born at GA of 40wks through emergency caesarian section due to poor progress of labor. She was admitted into the Newborn with abnormal skin. These series are crucial so as to enable the pediatrician have a high index of suspicion of its existence and to be equipped with the skills to tackle the numerous complications that follow the disease. They contribute to mortality and morbidity among children in Nigeria and the exact etiology is unknown. However genetic and environmental factors among others are commonly implicated.

This report is thus aimed at presenting these abnormalities which are rather rare and to highlight that early intervention improves the outcome in patients with these conditions.

Conclusion: Early recognition of this clinical entity and early institution of appropriate therapy can definitely reduce morbidity and mortality in neonates.

Key Words: Collodion Baby, Neonates, Genetic Disorder

Introduction

Collodion baby is a characteristic clinical entity which may precede the development of one of a variety of ichthyoses or occur as an isolated and self-limiting condition. The first clinical description of collodion membrane by Pérez in 1880 continues to be valid: “The baby’s skin is replaced by a cornified substance of uniform texture, which gives the body a varnished appearance”. The most important clinical data concerning collodion baby is the presence of disseminated or generalized ichthyosiform genodermatosis characterized by dry skin, scaling, generalized erythroderma and hyperkeratosis, reminiscent of fish scales. This type of dermatosis is also known by the generic name of ichthyosis. The tension exerted by the collodion membrane, distorts the features of the face and fingers. Rarely, the shedding of the membrane results in a normal integumen because shedding of the membrane results in erythema of varying intensity. The clinical types of ichthyosis depend on the mode of inheritance as well as clinical and anatomic/pathological data. Ichthyosis can be classified into three groups: true ichthyosis, ichthyosiform states and epidermolytic hyperkeratosis.

There are several subtypes of each group. Among the true ichthyoses are three subgroups as follows: autosomal dominant ichthyosis (ichthyosis vulgaris, ichthyosis simple, fish skin disease) X-linked recessive ichthyosis (ichthyosis nigricans, ichthyosis of the male, saurodermia) and autosomal recessive ichthyosis (laminar ichthyosis, non bullous congenital ichthyosiform erythroderma). Ichthyosiform states are recognized in the following syndromes: Sjogren-Larsson, Conradi-Hunermann, Rudd, Comel, Tay, Refsum, Netherton, Kid and Bid as well as erythrokeratoderma variabilis of Mendes da Costa and progressive symmetric erythrokeratoderma.

Neonatal ichthyosis, in its most severe form, is known
as harlequin ichthyosis, harlequin fetus or maligna kerato-
toma. Harlequin ichthyosis is also a keratinization disor-
der with extremely rare autosomal recessive hereditary
traits. ABCA 12 gene (adenosine triphosphate binding
cassette A 12), located at chromosome 2q33-q35, is rec-
ognized as the cause of lamellar ichthyosis and mutation
of this gene as being responsible for harlequin ich-
thyosis. The frequency of collodion baby is very low. It
is estimated that there are 1:300,000 cases of newborns
in the worldwide. We present these cases to highlight
its rarity and need for presentation early to avert compli-
cations that follow it.

Case Presentation

Case 1

B.H is a day old male baby, the first child of a consan-
guineously married couple of Fulani decent. The abnor-
mal appearance of the baby’s skin was noticed at birth.
Baby was delivered at home but mother presented im-
mEDIATELY to the hospital. On examination the baby
weighed 2.9 kilogram. There was ectropion and the skin
was semi transparent and peeling. Systemic examinat-
ion was essentially unremarkable. Based on these find-
ings, she was managed as collodion baby. The baby was man-
aged in an incubator. The temperature, hydration and
electrolyte status were monitored. The baby was man-
aged with prophylactic antibiotics. Adequate nutriti-
on was provided by the use of expressed breast milk.
She received IV fluids and antibiotics. Baby did well
and was discharged.

Fig 1a: Before Treatment

Fig 1b: After Treatment
Note the disappearance of all
skin features

Case 2

A.H is one day old female baby, the second consecutive
child of a consanguineously married couple of Fulani
decent. The abnormal appearance of the baby’s skin was
noticed at birth. Baby was delivered at home before
presenting in the hospital. The birth weight at presenta-
tion was 2.8 kg. On examination, there was ectropion and absence
of eyelashes and eye brows with an O-shaped mouth
(eclabium). The skin was semi transparent, and had a
parchment like feel with varying degrees of fissures at
groin, axilla and joint regions. The baby however died imme-
diately of sepsis in the hospital.

Fig 2a: Pictures of Case 2: Note ectropion
on the forehead and collodion membrane
on the body

Fig 2b: Note similar ectropion on the limbs

Case 3

Baby M.H, is a two day old male neonate, the fifth child
in a polygamous family setting of Fulani descent. The
parents are first cousins. The mother did not receive
adequate antenatal care and the patient was deliver-
ed at home by his paternal grandmother. The abnormal ap-
pearance of the baby was noticed at birth. The patient is
the third consecutive child of the mother with similar
presentation at birth. On examination the baby weighed 2.5
kilograms, with a length of 48 cm and an occipito-frontal circumference of
34 cm. There was ectropion and absence of eyelashes
and eye brows with an O-shaped mouth (eclabium).
The skin was semi transparent, and had a parchment like
feel with varying degrees of fissures at groin, axilla and
joint regions. Systemic examination was essentially un-
remarkable.

The baby was managed in an incubator. The tempera-
ture, hydration and electrolyte status were monitored.
Bland lubricants were applied to the skin to facilitate
desquamation. The baby was managed with antibiotics.
Adequate nutrition was provided by the use of expressed
breast milk. The Collodion membrane peeled off within 19 days
revealing normal raw skin underneath. Patient was sub-
sequently discharged home in a fair condition. The first
of the preceding sibling of the index patient died of
severe sepsis due to late presentation while the second
was managed in a teaching hospital and improved remarkably.

Case 4

NR is a female born at 40wks gestation through emergency caesarian section due to prolonged labor. APGAR score was 8/9 and birth weight 3.3kg. On examination we found a baby with parchment like, taut membrane covering the whole body. There was bilateral ectropion, a flattened nose, an O shaped mouth and dysmorphic fingernails. Other systems were grossly normal.

A diagnosis of collodion baby was made. Full blood count, Serum electrolyte urea and creatinine (SEUCr) were normal. She was nursed in an incubator at high humidity and was given IV fluids, antibiotics, multivitamins and genticine eye drops. Dermatologic and Ophthalmologic teams were invited to review, following which she received keratolytics, moisturizer and sufratyl gauze eye dressing. Blood culture results are negative.

By the 10th day there was appearance of normal skin. The patient was discharged on 11th day to Ophthalmology and Dermatology Clinic. Unfortunately, she was lost to follow up. It is important to note that none of these patients presented with sepsis, electrolyte imbalance or dehydration (safe the second who died of sepsis) because of the early and vigorous management which was given to them. These involve antibiotics, fluid management and joint management with other specialists.

Fig 3: Pictures of case 4 before treatment

Discussion

The term collodion baby applies to newborns who appear to have an extra layer of skin (known as a collodion membrane) that has a collodion-like quality. It is a descriptive term, not a specific diagnosis or disorder (as such, it is a syndrome). This is exactly noted in our patients who had extra layers of transparent skin.

When the Colloidion membrane was shed, the underlying skin appeared normal however a skin biopsy would be performed by the dermatologists to determine the specific type. The evolution reported in some studies included various types of ichthyosis: congenital ichthyosis erythroderma (43%), lamellar ichthyosis (19%), dominant ichthyosis vulgaris (12%) and normal skin (25%). However, surveillance and genetic counseling will continue during follow-up. Unfortunately, we lost our patient to follow up. This is because their parents are herdsman and are always migrating.

The natural course of collodion membrane is intriguing. For instance, approximately 75% of collodion baby will go on to develop a type of autosomal recessive congenital ichthyosis, either lamellar ichthyosis or congenital ichthyosis (ichthyosis erythroderma). Another 10% of cases the baby sheds this layer of skin and has normal skin for the rest of its life. This is known as self-healing collodion baby. This is akin to our series. The remaining 15% of cases could stem from variety of diseases involving keratinization disorders. Known causes of collodion baby include ichthyosis vulgaris and trichothiodystrophy. Less well documented causes include Sjögren-Larsson syndrome, Netherton syndrome, Gaucher disease type 2, congenital hypothyroidism, Conradi syndrome, Dorfman-Chanarin syndrome, ketoaciduria, koraxitrachitic syndrome, ichthyosis variegata and palmoplantar keratoderma with anogenital leukokeratosis.

There is a striking relationship between ichthyosis and collodion membrane formation. Lamellar ichthyosis may cause collodion baby. In these cases after the collodion membrane peels, the skin is almost completely erythematous and later on an almost generalized desquamation is observed. Soon after, the entire body surface becomes covered by thick scales. Such a thickening of the stratum corneum is called ichthyosis.

Three of our series were associated with consanguinity, the parents being first cousin. It has been noted with interest that since many of these conditions have an autosomal recessive inheritance pattern, they can be associated with consanguinity. Frenk and his cohort, in their study, noted that five spontaneously healing collodion babies recorded in large Swiss kindred all had consanguineous parents. Their distribution in the family indicates autosomal recessive inheritance. At birth they had the typical features of collodion babies.

The major cause of collodion baby syndrome is not well known. However it has been known to be inherited in an autosomal recessive fashion. Placental insufficiency and post maturity have also been implicated in some forms of collodion membrane formation. This could be due to the effects of DNA repair and transcription gene abnormalities in human pre-natal life. Trichoiodystrophy (TTD), a rare (affected frequency of 10−6) recessive disorder caused by mutations in genes involved in nucleotide excision repair (NER) pathway has also been implicated. However our series were all born at term with no placental abnormalities.

The Collodion baby is at the risk of high losses of transcutaneous fluid, risk of dehydration, hyponatremia and skin infections (gram-positive and Candida spp.). There is also the risk of pneumonia secondary to aspiration of desquamated material in the amniotic fluid. 
our first and third cases were managed in a humidified incubator and were given antibiotics but the second series died of sepsis due to late presentation. Taïeb reported that one of the most important decisions is placing the babies in incubators with humidifiers that vary from 90-100%. Fluid and broad spectrum antibiotics were also used. We did not document any electrolyte imbalance.

In the study by other workers affected babies were treated with emollients as prophylaxis. While one report documented systemic infections, the other study did not. In our two series, we used bland emollients for lubrication and no infection was documented. Specific practical guides on management in a resource poor country should include This includes half-hourly applications of emollients, frequent oiling of skin, nursing in humidified incubator with careful temperature monitoring, aseptic handling, investigation and treatment of signs of sepsis and, meticulous fluid and electrolyte balance. Constriction bands if present should be divided.

In the third case, shedding of the Collodion membrane occurred by the second week of hospital stay and no keratolytic agents were used.

**Conclusion**

Because this is a rare disease it is indispensable to have very clear and precise information on the steps to follow and the complications that may arise.

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**References**