Quick Derm Decision Making

Finding	Typical Appearance / Timing	Reassure	When to Escalate / Work Up
Vernix	White, greasy coating at birth	✓ Always	Never
Lanugo	Fine hair on back/shoulders/ears	✓ Always	Persistent + dysmorphism (rare)
Mottling (cutis marmorata)	Lacy, pink–purple with cold	✓ If resolves with warming	Persistent, fixed, or asymmetric → consider CMTC
Erythema toxicum	Erythematous macules + pustules, DOL 1–3	✓ Always	If vesicular, ill-appearing → consider HSV
Milia	Pinpoint white papules on face	✓ Always	Never
Petechiae	Non-blanching pinpoint lesions	Pressure-related localized	Diffuse, truncal, or ill infant → CBC, infection eval
Pustular melanosis	Pustules → hyperpigmented macules	✓ Always	Never
Hemangioma	Raised/red or deep bluish lesion	✓ Small, isolated	Facial, segmental, >5 lesions → PHACE / hepatic US
Nevus flammeus	Pink patch (eyelids, glabella, nape)	✓ Fades over months	Persistent facial lesions ≠ salmon patch
Port-wine stain	Flat, dark red/purple, unilateral	No	Ophtho ± neuro eval if trigeminal
Café-au-lait	Light brown macules	⩽2 small lesions	⩾6 or large → genetics (NF1)
Congenital sacral dermatosis	Blue-gray sacral pigmentation	✓ Always	Atypical location → document carefully
Aplasia cutis	Scalp ulcer/absent skin	Small, superficial	Large, midline, pulsatile → imaging
Umbilical cord	Drying stump	✓ Normal separation	Erythema, drainage, odor → omphalitis