“What’s My Line? is a panel game show which originally ran in the United States on the CBS Television Network from 1950 to 1967, with several international versions and subsequent U.S. revivals. The game tasks celebrity panelists with questioning contestants in order to determine their occupations. It was the longest-running U.S. primetime network television game-show. The show won three Emmy Awards for ‘Best Quiz or Audience Participation Show’ in 1952, 1953, and 1958 and the Golden Globe for Best TV Show in 1962.” (Wikipedia, 2014)

WHAT’S MY LINE?
Guest Participant’s Answers
• All day long I handle an obtuse, time-consuming, and totally anti-social data entry system.
• I love my job. (Mostly.)
• I improve and sometimes save countless lives during a brief, often sporadic 10- to 20-minute encounter.
• I am considered a go-to guru for innumerable people.

• I am considered a know-nothing shaman by a few people.
• Most babies and children generally are enamored with me.
• Many babies and teens hate me for a brief minute every day. (See next line.)
• I manage an annual million-dollar inventory of perishable vaccines.
• I am considered a dispensable industrial cog by most large organizations, hospitals, and insurers.
• I am considered an indispensable asset by most families who use me.
• My opinion or knowledge of the nuances of medications hardly ever matters when dealing with a therapeutic formulary.
• I am continuously bombarded with ludicrous regulations from legislators and other people who know nothing about medical care. (Think continuing medical education on opioids; pens and pads from pharmaceutical companies.)

What’s my line? I am the General Pediatrician.

Being a successful and content general pediatrician usually requires three things: 1) keen observation skills (babies do not talk; 13-year-old girls and boys often do not talk); 2) taking great pleasure in dealing with young patients of all ages — from newborn to adolescence; and 3) excellent background training in the fundamental common and uncommon problems and diagnoses encountered in daily practice — from genetic disorders (eg, Williams syndrome) to psychiatric disorders (eg, anxiety disorders) to infectious diseases (eg, meningococcal and pneumococcal presentations), etc.

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Figure 1. A healthy, fully immunized 4-month-old white girl with a lengthy, peculiar red rash on the dorsum of the entire left leg.
Furthermore, the pediatrician’s odds of long-term success on a professional level increase exponentially with some of the following circumstances: professionally compatible pediatric partners; organizational owners who are more health-care oriented than bean-counter oriented; user-friendly electronic medical programs; and reasonably higher personal income.

But maintaining a happy longevity in general pediatrics will often require streaks of good luck, with hopefully only an occasional streak of bad luck. Some of the patients in your practice will die, both predictably and unexpectedly. But, it is rarely ever anyone’s fault (despite the legions of trial attorneys who claim otherwise). More importantly, you cannot be an alarmist or doomsayer with every common but potentially deadly symptom or sign in your patients — you could not effectively function that way as a general pediatrician. The keys to avoiding many of the streaks of bad luck are your careful physical examination and accessible follow-up of many seemingly innocuous findings, along with having generally reliable caregivers.

Take, for example, the following mundane findings and some of their more common causes. Very rarely in my career have these turned out to be a possibly lethal finding (examples of the more serious diagnoses are indicated in brackets):

- Fever 104°F = roseola or herpangina; [septicemia, meningitis, Kawasaki]
- Four petechiae = enterovirus or strep pharyngitis; [early hemolytic uremic syndrome or meningococcemia]
- Weight loss = sport season, better diet, grief reaction, medication side effect; [anorexia nervosa, Crohn’s disease]
- Bruising = trauma, viral infection; [leukemia, aplastic anemia]
- Headache = migraine, viral infection, tension; [retinoblastoma, medulloblastoma].

WHAT’S MY LINE? IDENTIFY THE RED STREAKS

In the following cases, assume all of the patients are otherwise healthy, afebrile, and fully vaccinated.

Case 1
A healthy, fully immunized, 4-month-old white girl presents with a lengthy peculiar linear rash on the dorsum of the entire left leg (Figure 1). The lesions are raised and plaque-like, and almost seborrheic in appearance. The rash is not pruritic, has been present for 1 week, and is associated with no other systemic symptoms, signs, or other rashes.

What’s my line?

Case 2
A healthy 20-year-old white woman presents with a mildly pruritic, linear crop of raised, plaque-like, seborrheic-like lesions on the dorsum of her right leg that has been present for nearly a month (Figure 2). The string of lesions is almost purpuric-appearing in spots, which may be from her scratching them. She has no other rash, symptoms, or physical findings. She is currently taking estrogen-containing oral contraceptive pills daily.

What’s my line?

Case 3
A previously healthy 12-year-old white boy abruptly developed a moderately swollen and reddened, very tender left thumb and volar thenar eminence (Figure 3). The severe reaction seemed to have been triggered by a minor insect sting of the thumb 3 days prior to presentation. A fairly lengthy, narrow, and tender red line now extends proximally and cephalad from his wrist up to his axilla. He has also now developed some malaise, sweating, and possibly a parentally detected low-grade fever.

What’s my line?

Case 4
A previously healthy 10-year-old white boy deeply scraped the metacarpophalangeal area of his left thumb on a rusty fence 48 hours earlier (Figure 4A). Therapy with oral cephalaxin was initiated 24 hours earlier in the urgent care center. He has full range of motion of his thumb, fingers, and wrist, but he has now developed this mildly reddened, slightly painful red streak arising from his thumb area and ascending his forearm.

What’s my line?

After 24 hours of oral clindamycin, the boy developed a mildly painful and more intense cellulitis of the left hand and lower forearm (Figure 4B). The scrape site is also more reddened, but still not draining. Obviously, neither the cephalaxin nor the clindamycin was working.

What’s my line now?

Case 5
Two days ago, this previously healthy 9-year-old white boy stepped on a nail that was stuck in a board lying around his family’s farm (Figure 5). What are the critical questions and examination aspects of the foot?

What’s my line?

DISCUSSION

Case 1
Initially, you think that the linear lesion in this infant (Figure 1) appears to be a contact dermatitis reaction, such as the Koebner phenomenon from poison ivy. But the girl’s negative medical history and the rash’s raised fleshy, orange-colored appearance points you in another direction — an epidermal nevus.
Epidermal nevus can also occasionally present as a linear lesion, known as inflammatory linear verrucous epidermal nevus (ILVEN). It too has a rather warty appearance but tends to be browner in color and more scaly, pruritic, psoriasitic, and plaque-like in appearance. However, you are most concerned about the possibility of a nevus sebaceous, which often presents at birth. This sebaceous lesion, however, typically appears primarily on the face and scalp. This is an important differential diagnosis, as the sebaceous lesions have a tendency to undergo malignant transformation, particularly into basal cell carcinoma, in adulthood. Surgical removal and its timing are controversial for this sebaceous lesion.\textsuperscript{1,2}

Further investigation of the lesion in this infant, however, leads you to conclude that it is actually lichen striatus, which is a self-limited (average of 6 months in duration) inflammatory dermatitis of unknown or viral etiology. It is more common in girls, and the average age of onset is age 4 years. The lesions are usually continuous, unilateral, narrow, curvilinear, follow the lines of Blaschko, and are located on the extremities. Observation over the next 3 to 24 months is necessary to ensure that the lesion spontaneously resolves (as is the norm for lichen striatus). Otherwise, a biopsy may be necessary to confirm the diagnosis. Unlike topical steroids, calcineurin inhibitors have shown some benefit.\textsuperscript{1}

The lesion in this infant spontaneously resolved at age 9 months.

**Case 2**

The skin finding in the 20-year-old woman shown in Figure 2 is a lichen striatus lesion similar to that of Figure 1. Occasionally, the lesions of lichen striatus can be discontinuous, as in Figure 2. Due to her pruritus, a trial of topical steroids and oral cetirizine were initiated, with modest success. Her lesion also spontaneously resolved over a period of 6 months.

**Case 3**

The combination of tenderness, redness, and swelling signifies an early cellulitis of the thumb (Figure 3). The linear streak extending up the volar aspect of the forearm is a secondary lymphangitis. The most common pathogen causing traumatic, non-surgical acute lymphangitis is bacterial. Recreational, occupational, and bite history are important. Although collection of a clinical specimen is suggested, the yield is virtually non-existent from cellulitis lesions.\textsuperscript{3}

The most common bacteria recovered from lymphangitis patients is *Streptococcus pyogenes*, followed less frequently by *Staphylococcus aureus*, *Pasteurella multocida* (dog or cat bites), and rarely by sporotrichosis (fungal and gardening), erysipelothrix (zoones), and gram-negative (traumatic) infections.\textsuperscript{3} Clinicians should also carefully examine, palpate, and assess for full range of motion of the infected extremity to discern any signs of bone pain, teno-synovitis, or retained foreign body...
or stinger. If any of these three signs is apparent, inpatient and surgical consultation is recommended.

To provide coverage for *S. pyogenes* and methicillin-susceptible staphylococcal pathogens, this patient was started on a 10-day course of cephalexin (250 mg three times daily). Improvement of both the cellulitis and lymphangitis was seen within 24 hours. The patient had an excellent overall clinical response over the next 48 hours.

**Case 4**

As a result of the traumatic scrape of his thumb on a rusty fence, this 10-year-old boy developed a secondary lymphangitis of his left hand and forearm ([Figure 4B](#)). To provide coverage for the most commonly recovered pathogens (*S. pyogenes* and staphylococcal species), cephalexin therapy was initiated. However, the next day no improvement was noted. His wound was then cultured and his antibiotic was switched to clindamycin on the presumption that methicillin-resistant *Staphylococcus aureus* (MRSA) was the most likely pathogen. However, after 24 hours of clindamycin, the hand showed distinct worsening of the cellulitis with more erythema and swelling ([Figure 4B](#)).

What’s my line now?

Should we now consider hospitalization in order to use multiple broad-spectrum antibiotics intravenously? Although this would be a very reasonable approach, after much discussion with the parent, you chose instead to implement a 24-hour oral antibiotic trial of gram-negative coverage with daily follow-up. You considered the possibility of both gram-negative enteric patho-

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**Figure 4.** (A) A previously healthy 10-year-old white boy who deeply scraped the metacarpophalangeal area of his left thumb on a rusty fence 48 hours earlier. Note the red streak ascending the forearm. (B) After 24 hours of oral clindamycin, the boy has now developed a mildly painful and more intense cellulitis of the left hand and lower forearm.

**Figure 5.** Two days ago, this previously healthy 9-year-old white boy stepped on a nail that was stuck in a board lying around his family’s farm. Note the red streak ascending the plantar arch.
gens such as *Escherichia coli*, along with the “water bugs” *Pseudomonas* and *Aeromonas*, based on the source of the infection. Only one oral antibiotic, ciprofloxacin, would closely fulfill this dual requirement. Ciprofloxacin, which is quite inexpensive now, is considered by the U.S. Food and Drug Administration (FDA) to be safe enough to routinely and similarly use in children as young as age 12 months for complicated or refractory urinary tract infections.

The clindamycin was discontinued, and therapy was started with oral ciprofloxacin (500 mg twice daily) for 7 days to provide coverage for most of the more common gram-negative pathogens. Within 24 hours, the redness and swelling had dissipated somewhat. No bone or tendon tenderness was noted. After 48 hours, the wound was resolving well, and the lymphangitis had disappeared.

The wound culture was now growing *Aeromonas* species that were susceptible to ciprofloxacin and a few other third-generation cephalosporins. He continued to improve and recovered without sequelae after 1 week of antibiotics.

**Case 5**

This young farm boy’s wound on his foot showed a classic appearance of ascending lymphangitis. Further questioning uncovered that he had indeed been wearing a sneaker/tennis shoe when he stepped on the nail. Further examination of his foot revealed no bone tenderness in the entire area upon deep palpation, and no tendon pain upon range of motion of the toes or forefoot. Therefore, you were comfortable with the likelihood that he had merely sustained a not-so-deep puncture wound without any bone or tendon involvement, or any retained foreign body.

According to Long and Pickering’s pediatric infectious disease textbook, the most likely pathogen to be recovered from this particular type of puncture wound is *Pseudomonas auginosa*, and only occasionally *Streptococcus* and *Staphylococcus*. Although some experts would be concerned by the abrupt onset (within 3 to 4 days) of the lymphangitis, in my experience I have found the lymphangitis to often occur fairly quickly with *Pseudomonas* foot infections.

The use of two different antibiotics in this scenario to cover for *Pseudomonas*, *Staphylococcus*, and *Streptococcus* would be reasonable as well.

Consequently, you initiate therapy with oral ciprofloxacin (500 mg twice daily) and ask the boy to return tomorrow. His course was one of rapid resolution for the lymphangitis, and he did not develop any complications over the next 48 hours.

**CONCLUSION**

When trying to determine the etiology of “What’s my line?” in infected-looking red streaks on the extremities of pediatric patients, you must be quite
cautious about attributing the causative pathogen of lymphangitis to only streptococcal and staphylococcal species. You must perform a thorough history about the source of the infection and be alert to the alternative possibility of gram-negative pathogens, particularly in outdoor injuries or persistent unresponsive infections of the foot and hand. Importantly, if any puncture or open wound shows any notable signs of tendon or bone tenderness, prompt admission and further consultation is advisable.

Carefully monitor any other linear, raised, and seborrheic lesions of the extremities for resolution over at least a 2-year period before attributing them to more benign causes, such as lichen striatus or lichen planus. These linear lesions may rarely be caused by a similarly appearing epidermal nevus sebaceous, which has the potential to become malignant (Figure 6). The young woman in Figure 6 was referred directly to a dermatologist for a biopsy (results are pending). This is a good example of when you should refer one of your patient’s to a specialist.

I am hopeful that all of my pediatric colleagues will experience only streaks of good luck. The streaks of bad luck can be absolutely brutal and heart-wrenching.

REFERENCES