Guess That Rash

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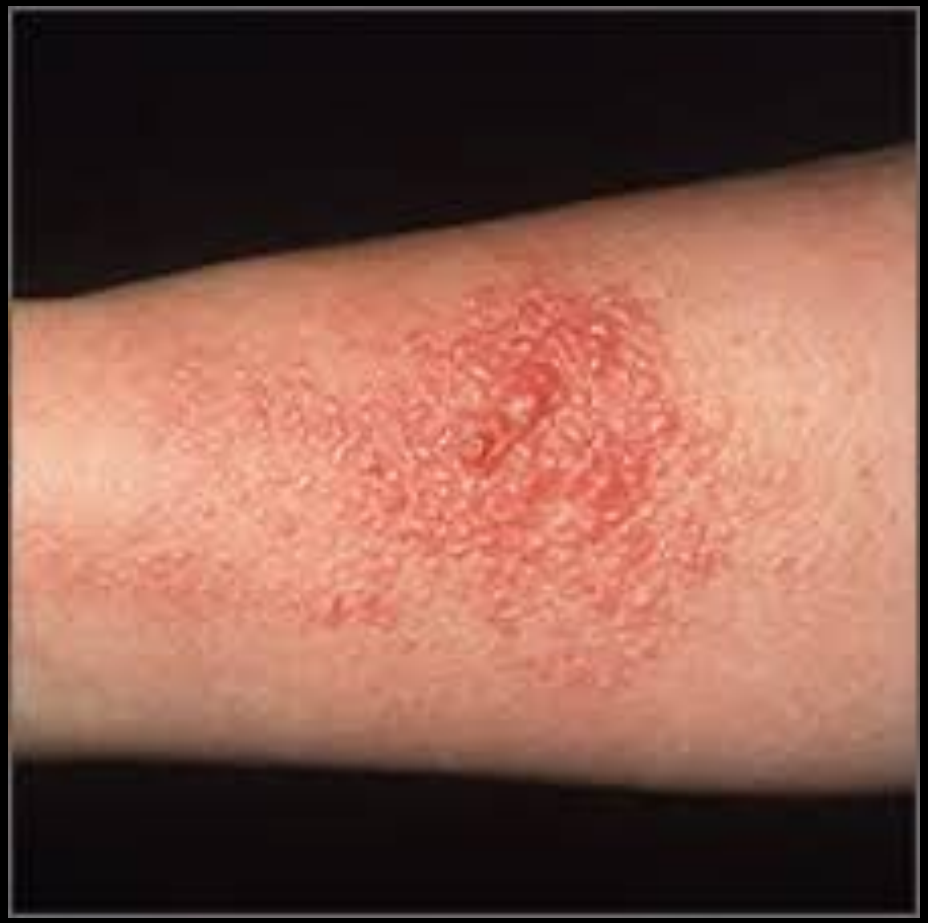
Disclosures

No disclosures

20 year old man presents with the rash shown below. He has a history of atopic dermatitis as a child. Hobbies include anything outdoors and he gardens and hikes regularly. He comes to see you for this itchy rash.



This rash is most likely:

A. Atopic dermatitis

B. Sporotrichosis

C. Rhus dermatitis

D. Primary cutaneous nocardiosis

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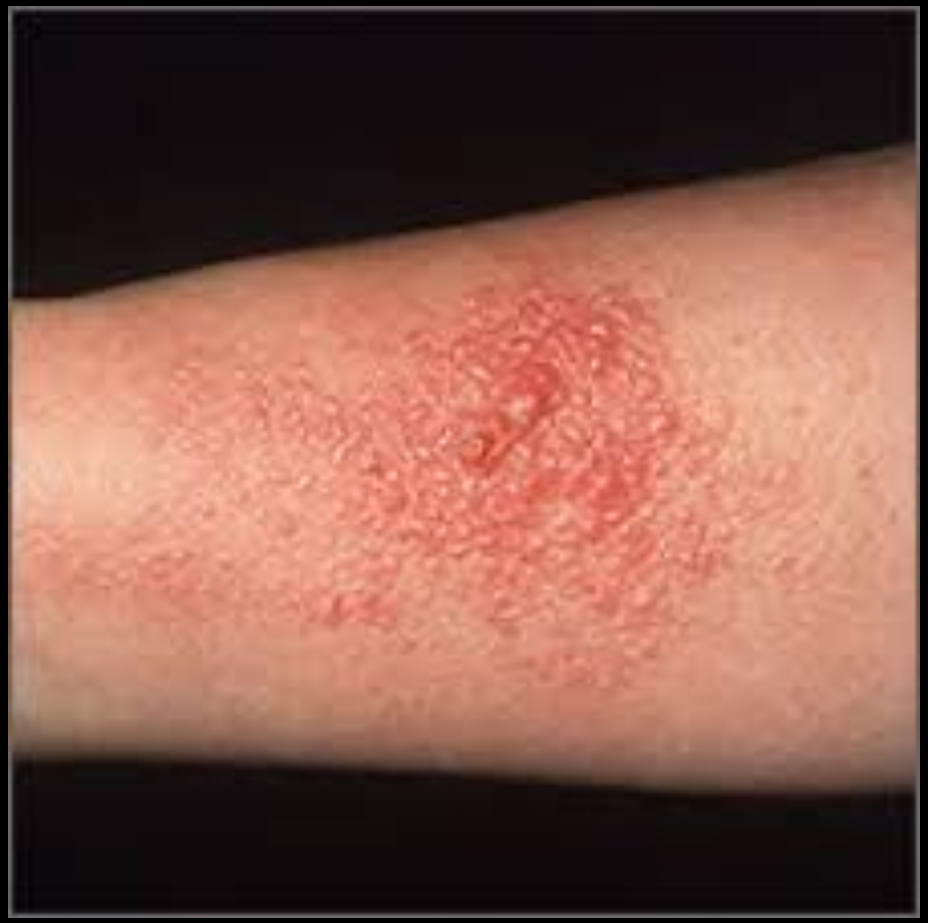


Rhus Dermatitis

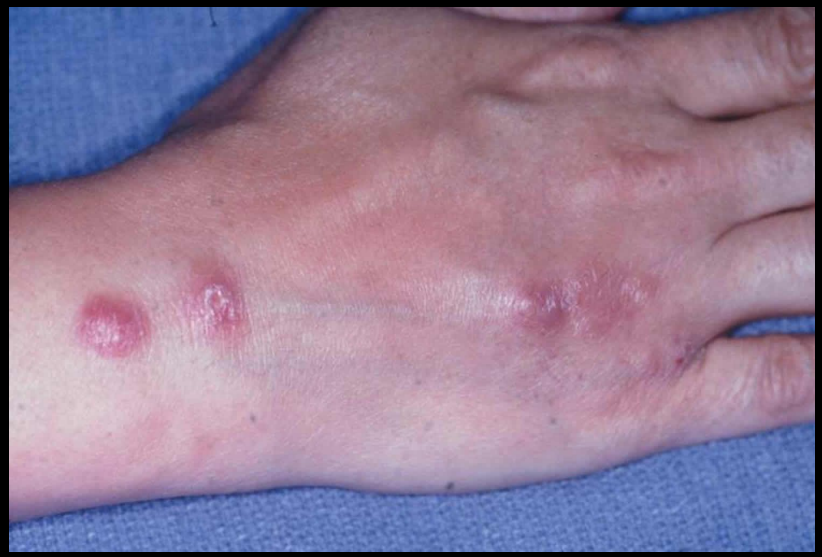
Poison Ivy

Poison Oak

Poison Sumac

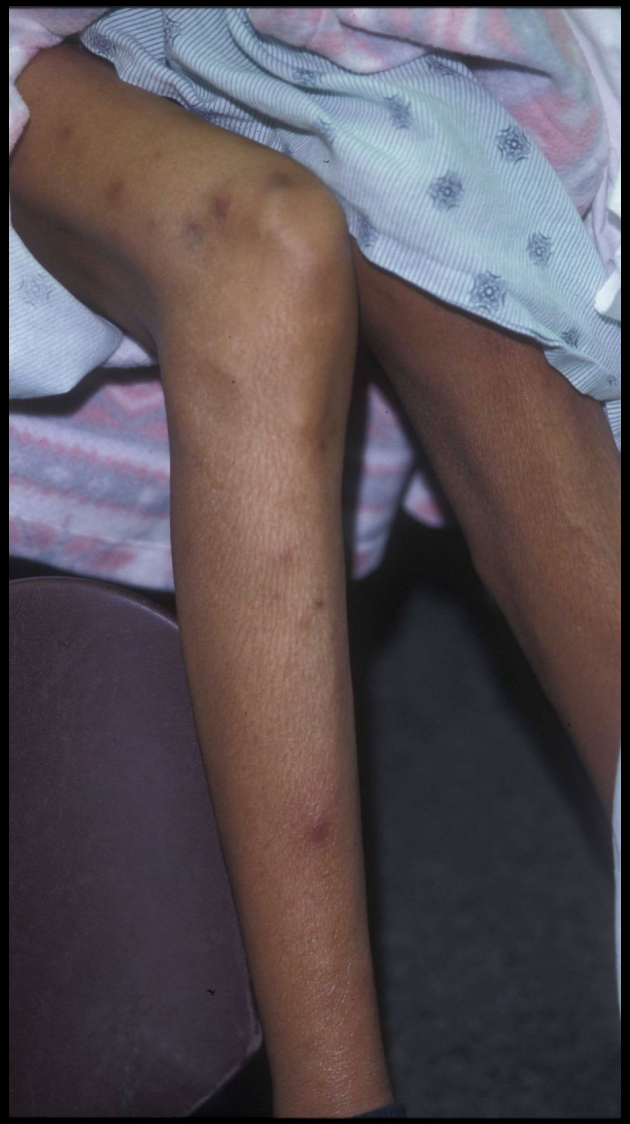
Sporotrichosis

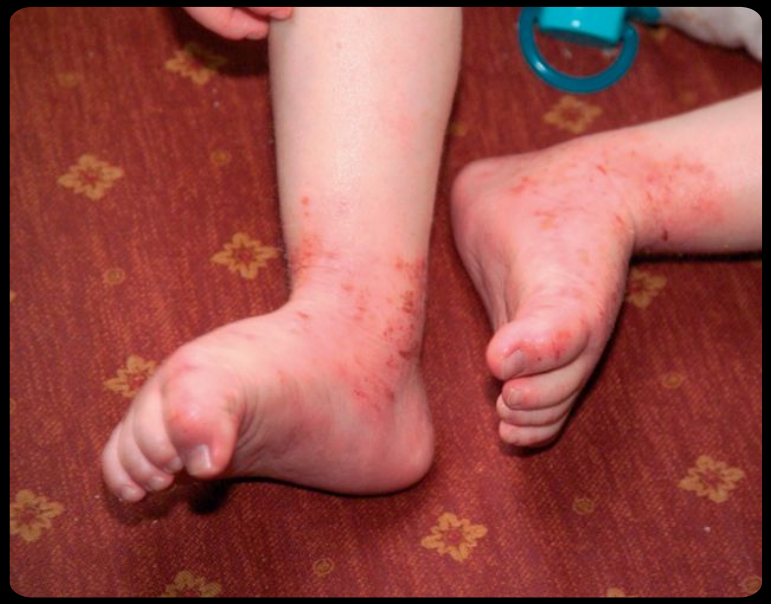
- Subacute to chronic infection caused by fungal genus *Sporothrix*
- Introduced into the skin by “traumatic inoculation” (e.g., prick by rose thorn)
- Can involve other organs in immunocompromised patients



Primary Cutaneous Nocardiosis

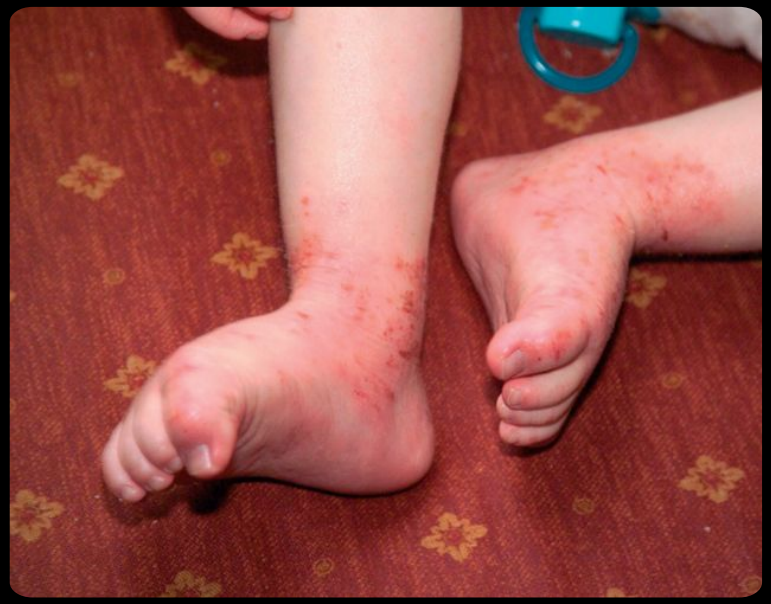
- Painful skin lesions
- May be associated with regional lymphadenopathy and mild systemic symptoms
- Occurs in patients with cell mediated immunodeficiency





Colton is 2 year old brought in to see you by his mother. He has excoriated, scaly, erythematous patches on his wrists and ankles. His mother has allergic rhinitis. He most likely has:

A. Nummular eczema
B. Lichen simplex chronicus
C. Atopic dermatitis
D. Prurigo nodularis



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Atopic Dermatitis

- An eczematous cutaneous eruption often referred to as “eczema”
- More common in children than adults
- Can be triggered by allergens
  - inhalant
  - food

Colton is most at risk of developing which other condition:

A. Eosinophilic esophagitis
B. Contact allergies to rubber
C. Acid reflux
D. Asthma

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Atopic Dermatitis

One of the 3 genetically related atopic diseases:

1. **Asthma**
2. **Atopic dermatitis**
3. **Allergic rhinitis**

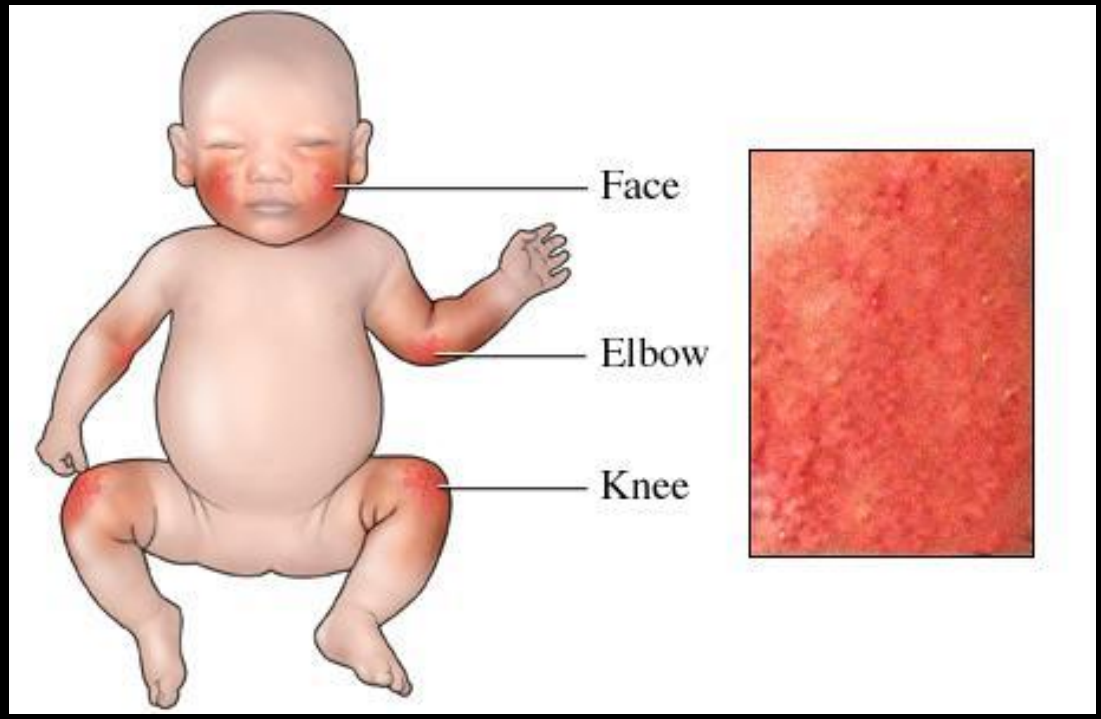
“Atopic March”

Suggestions have been made to include Eosinophilic Esophagitis as a 4th component

Atopic Dermatitis: History

- **ITCHING!!!**
- **Rash**
- **May be associated with certain allergen exposure (but development of rash may take hours)**
- **Very steroid responsive**

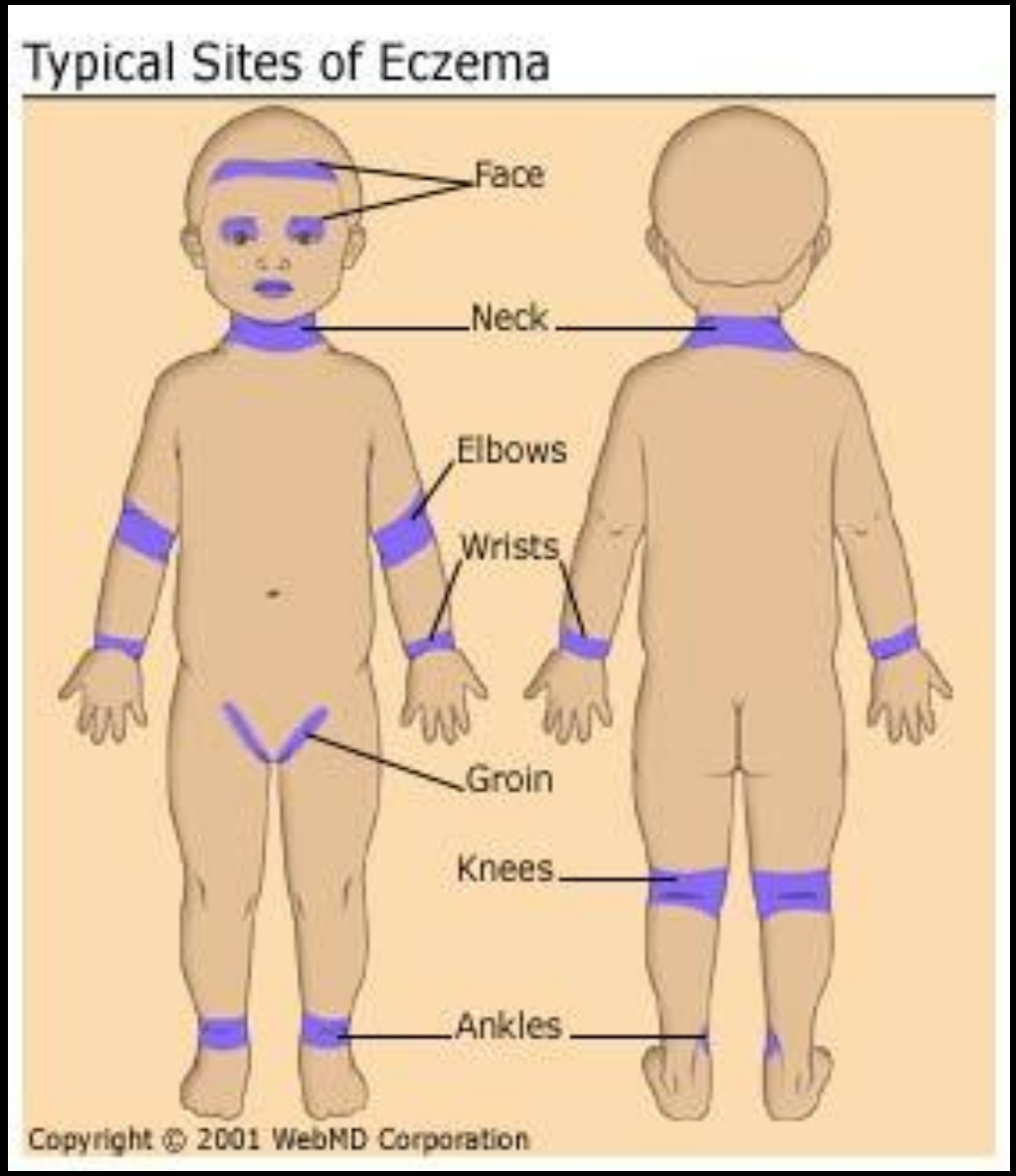
Atopic Dermatitis: Physical



- In infants, can occur on scalp/face, diaper area

Atopic Dermatitis: Physical

In older children & adults, AC fossae, behind knees, ankles, wrists, neck



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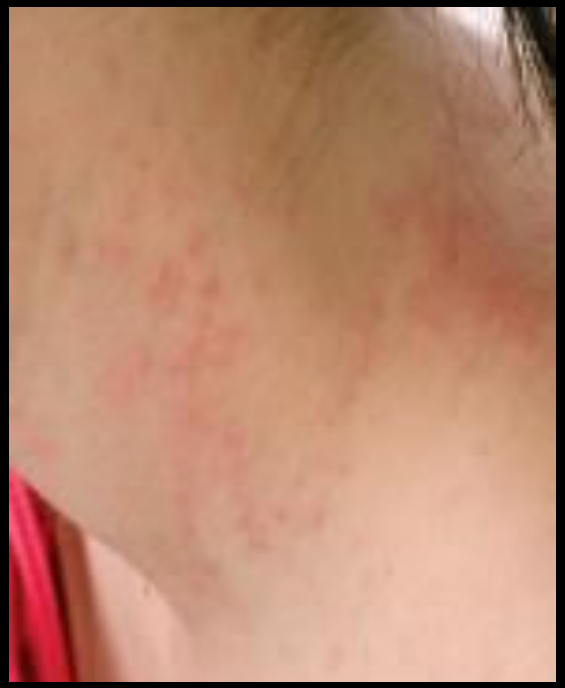

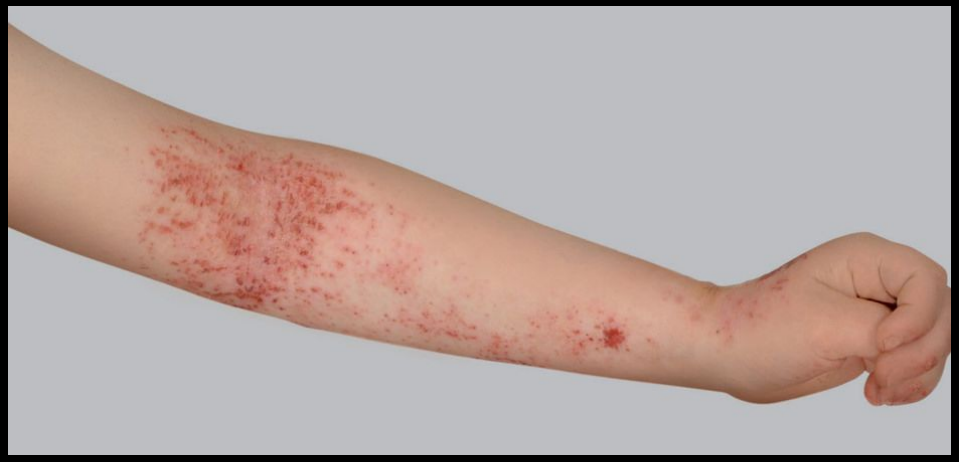

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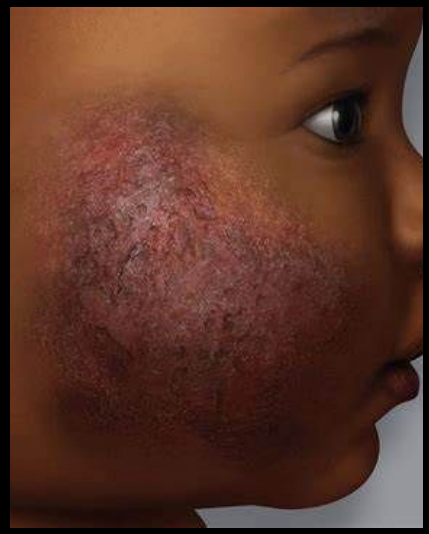
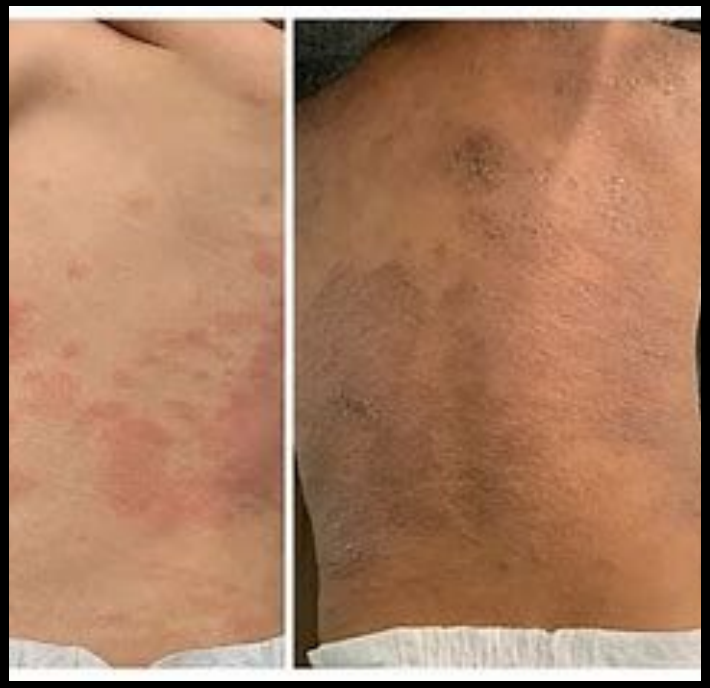
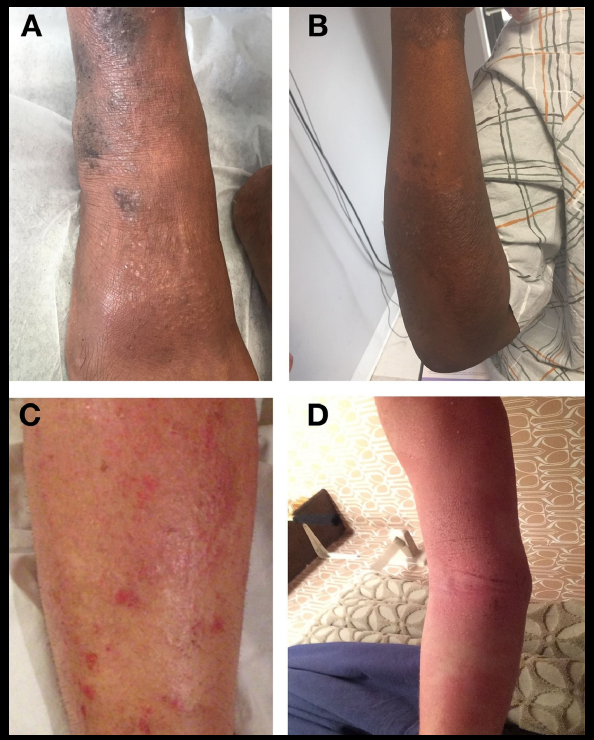
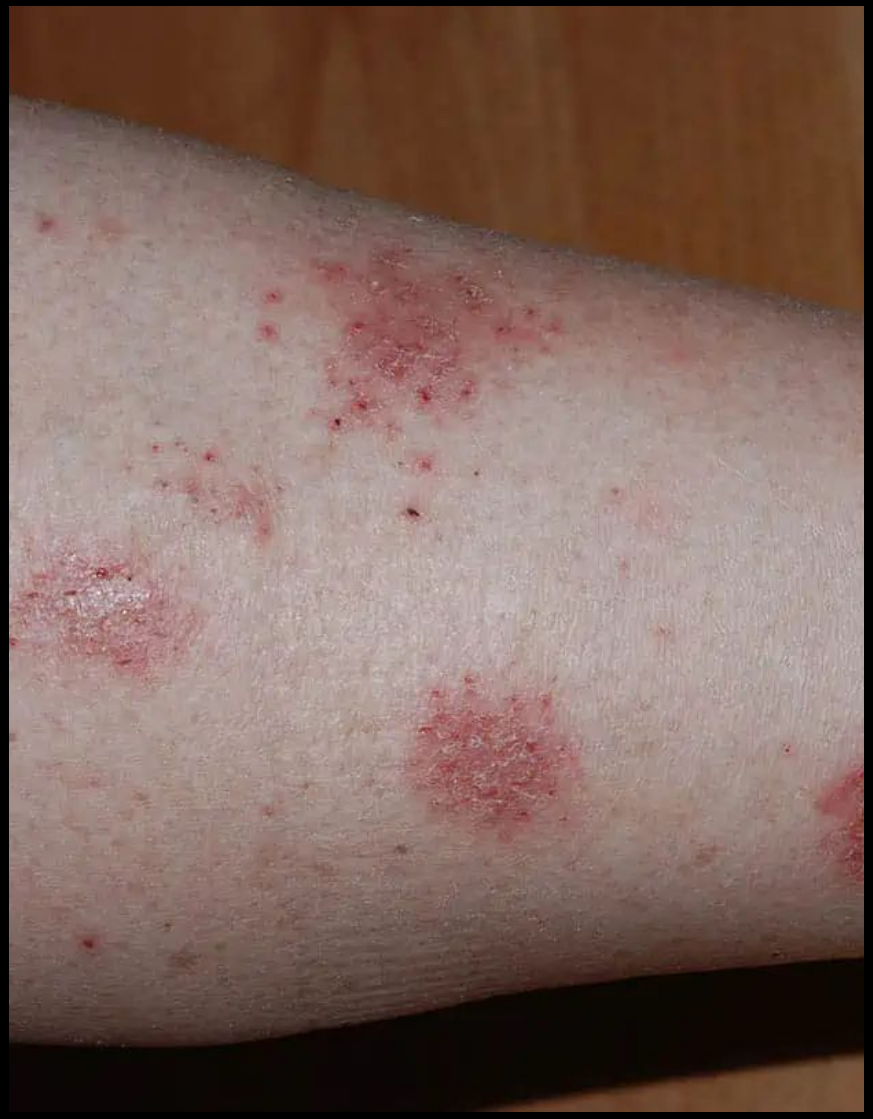


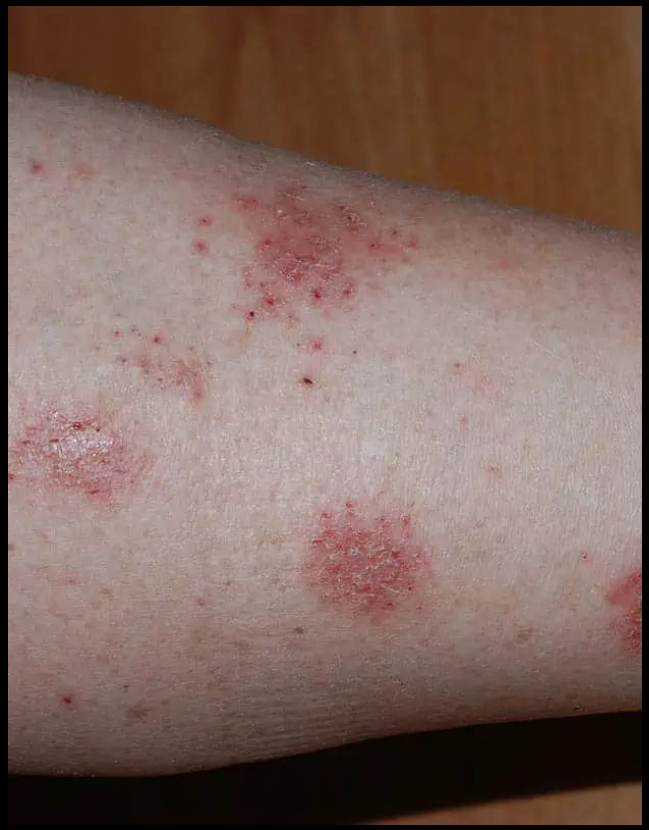


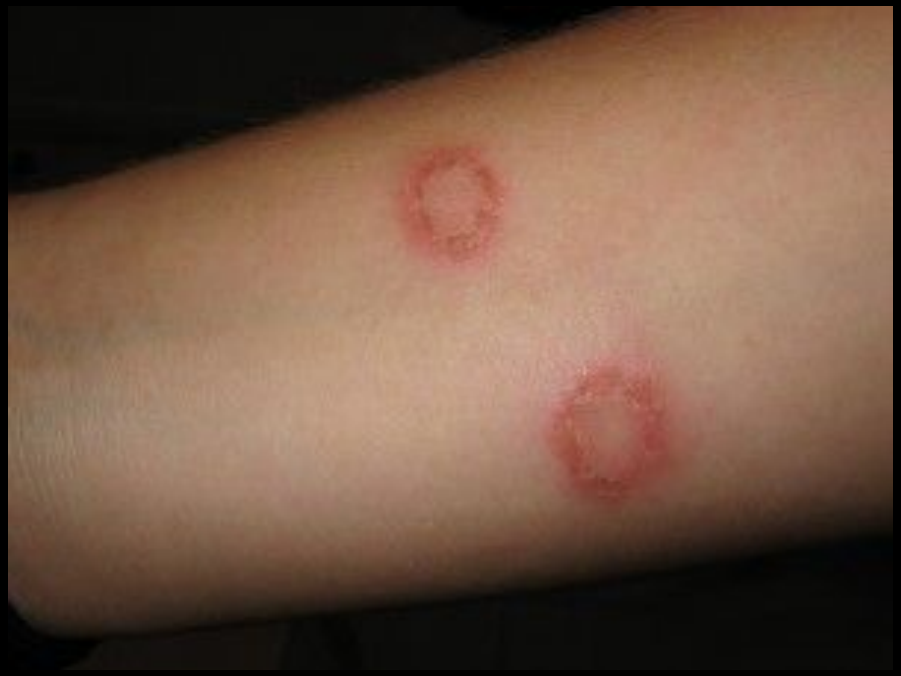


Nummular eczema

- Most often affects extremities, occasionally lower trunk
- May be idiopathic, but other possibilities include atopic dermatitis, contact dermatitis





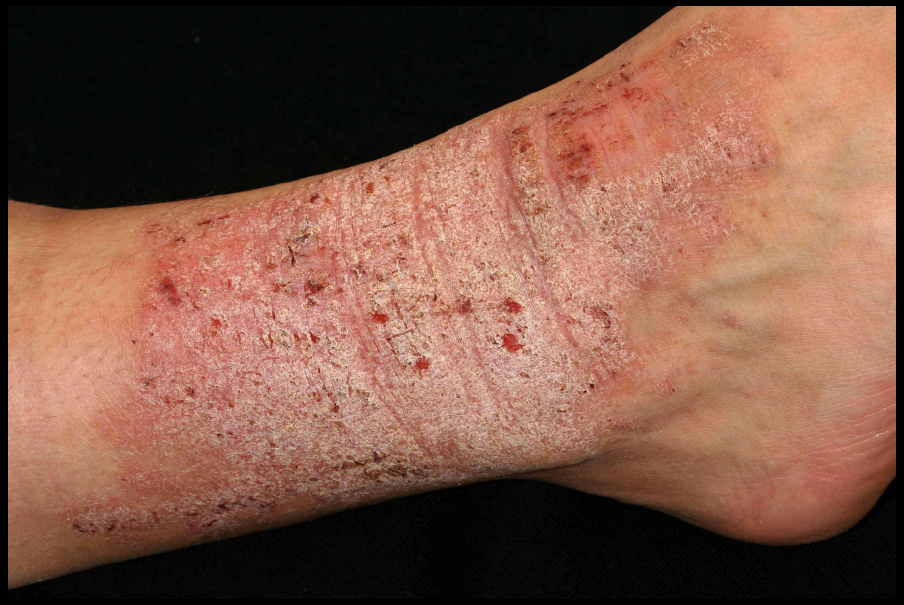


Nummular eczema

May be mistaken for tinea corporis

Lichen Simplex Chronicus

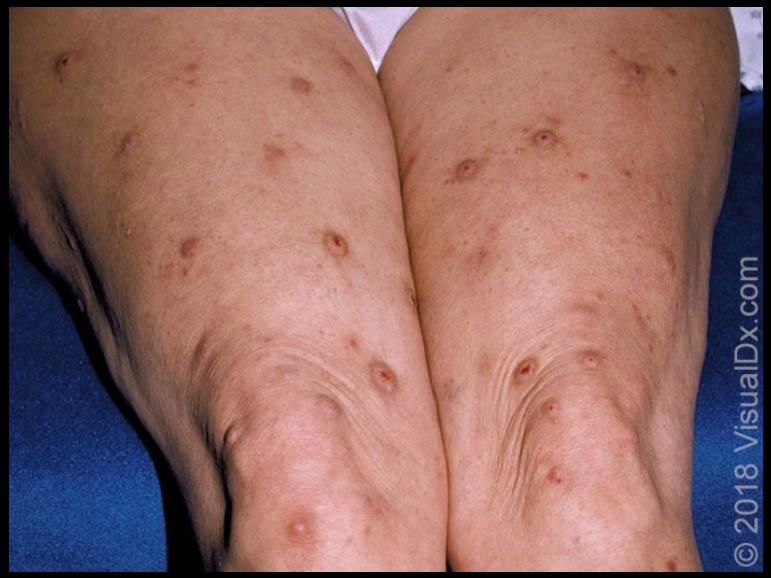
- Chronic localized pruritus with secondary dermatitis
- Etiology often elusive
- Consider work up for pruritus



Pruritus – Systemic Causes

- Chronic renal disease
- Cholestatic liver disease
- Hyper or hypothyroidism
- Diabetes mellitus
- Polycythemia vera
- Iron deficiency anemia
- Lymphoma
- Myelodysplastic Syndrome
- HIV
- Medications

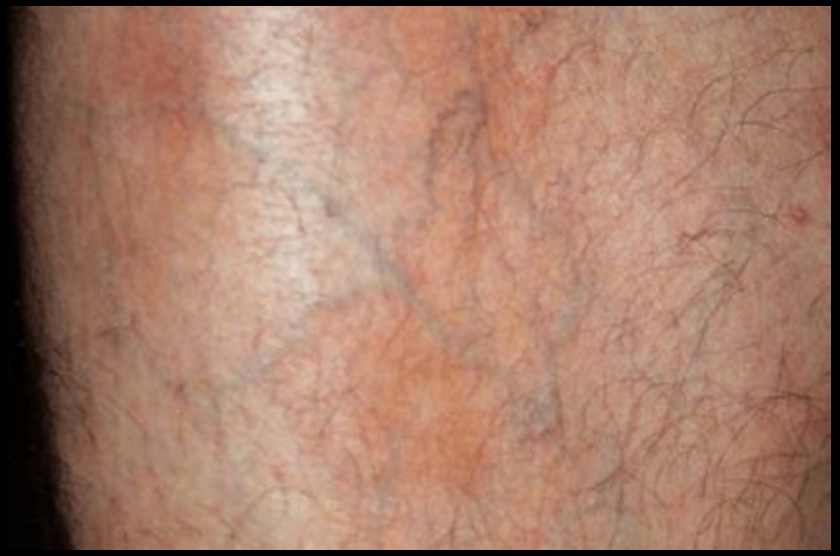
Prurigo Nodularis



- Uncommon
- Affects older adults
- Chronic itching
- Frequently associated with history of atopic dermatitis or h/o itching
- Results from frequent scratching over a period of time

Colton was lost to follow up. He returns at 15 YO. His eczema has been improved overall, but he continues to have the nonpruritic rash below, which persists, despite using his topical medication most days for years. You should advise the following:

A. Continue the topical cream. The rash is almost gone.
B. See a dermatologist to get the rash biopsied.
C. Food allergy testing
D. Stop using the cream



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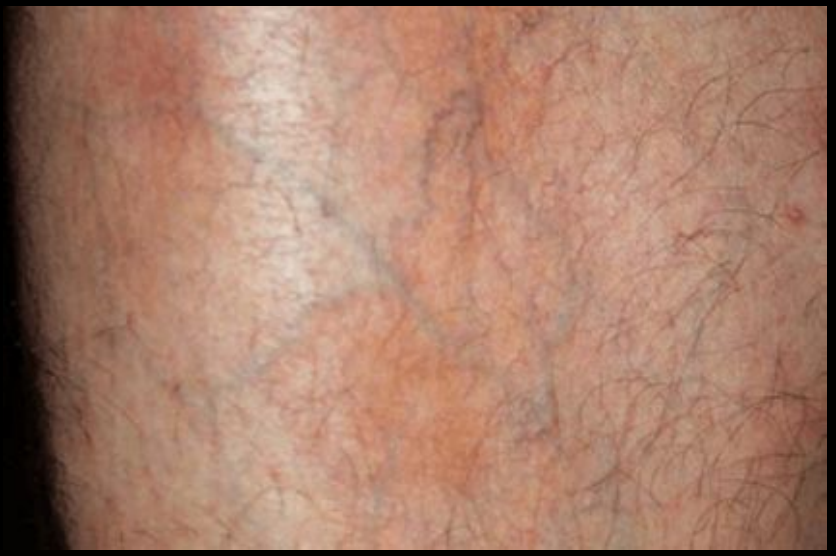
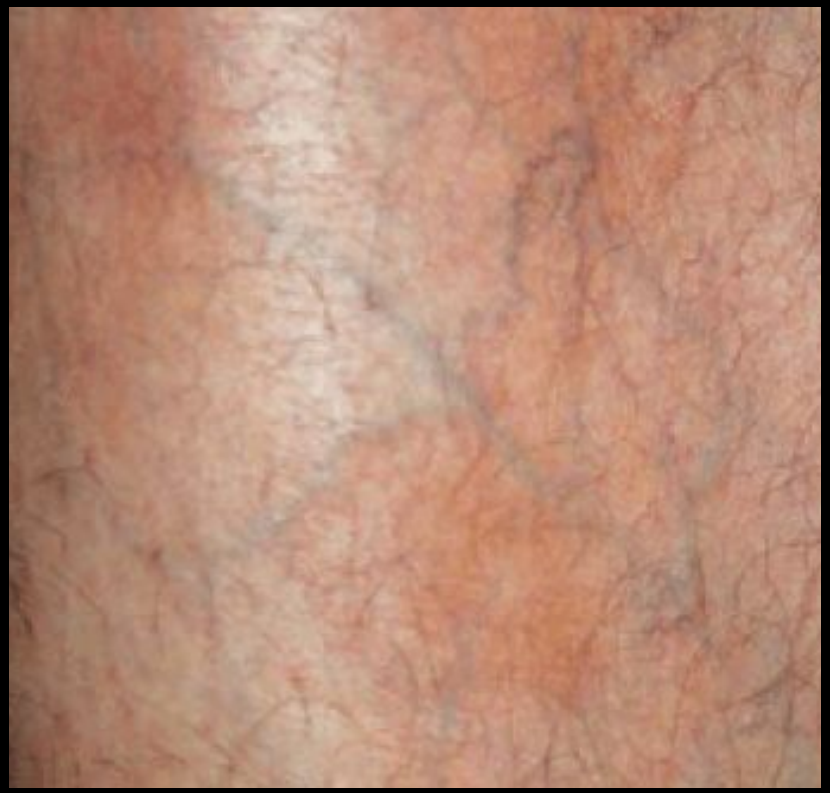


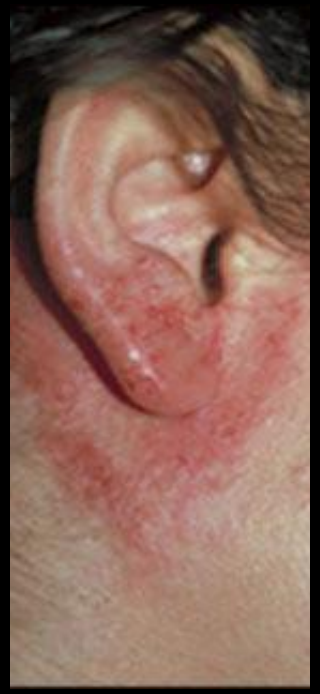
Skin Atrophy due to topical steroids

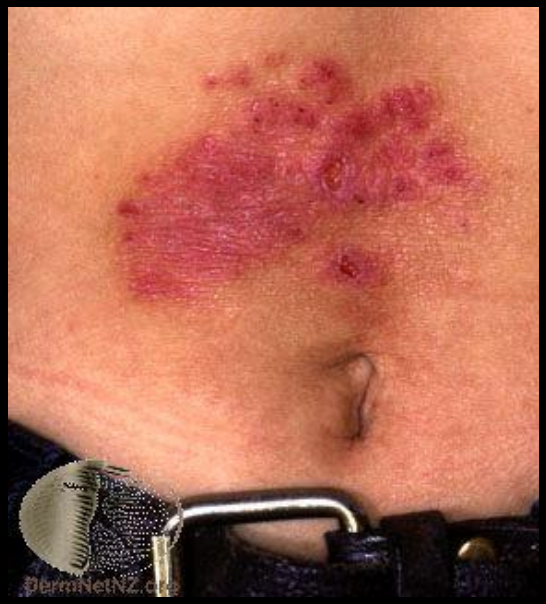


- Explain how to use topical steroids
- Use for no more than 7 consecutive days on face, neck, skin folds and 14 days elsewhere
- Start at onset of rash
- Caution with prescribing “PRN”

Tina has a history of developing rashes from belt buckles and buttons in jeans. She also develops rashes from earrings and other jewelry. Tina most likely has:

A. Urticaria
B. Angioedema
C. Atopic Dermatitis
D. Allergic contact dermatitis





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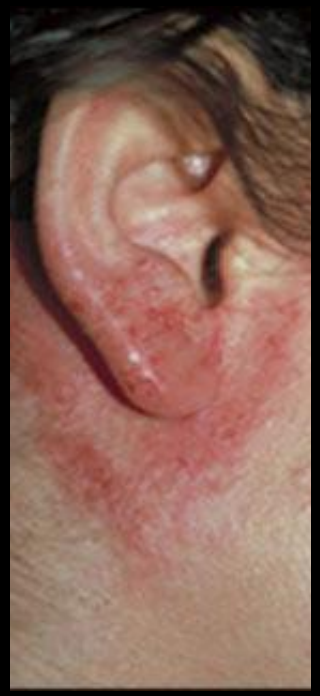

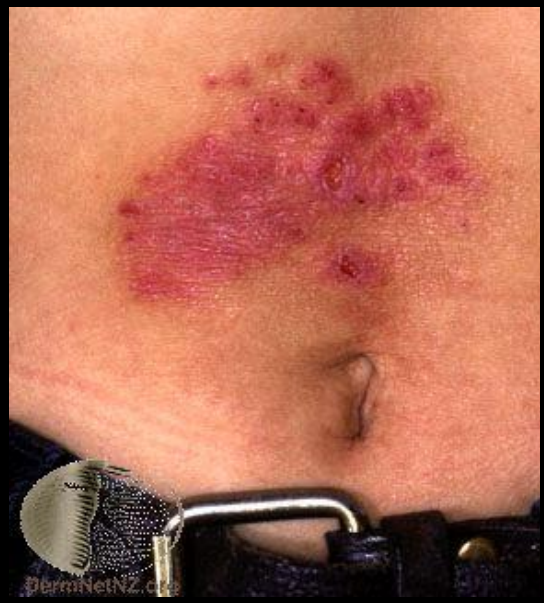

Tina is most likely allergic to:

A. p-phenylenediamine
B. Balsam of Peru
C. Nickel
D. Titanium

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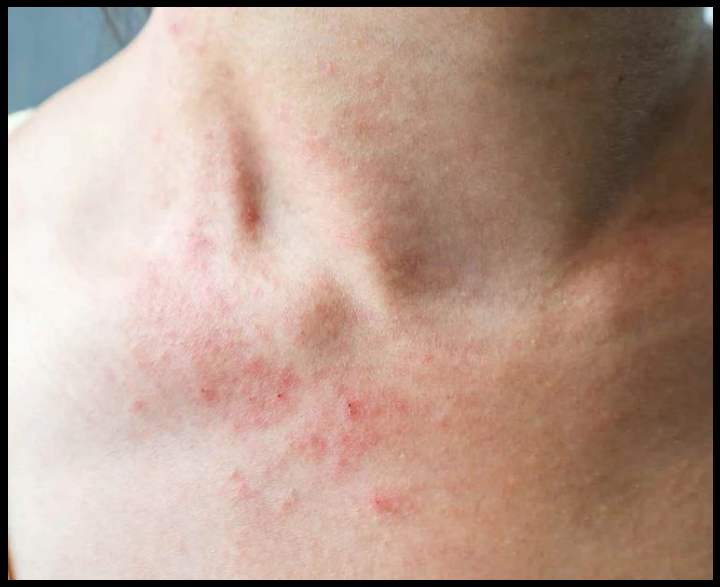
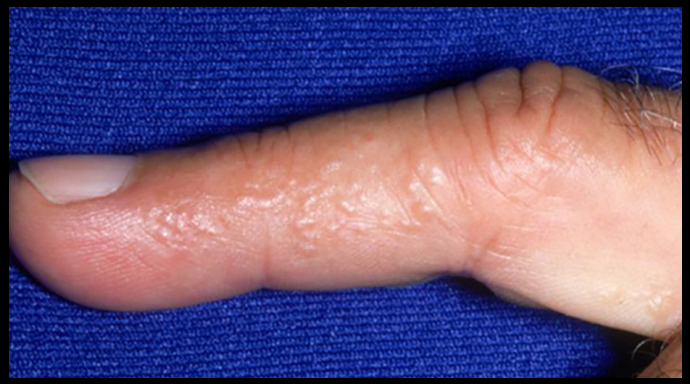
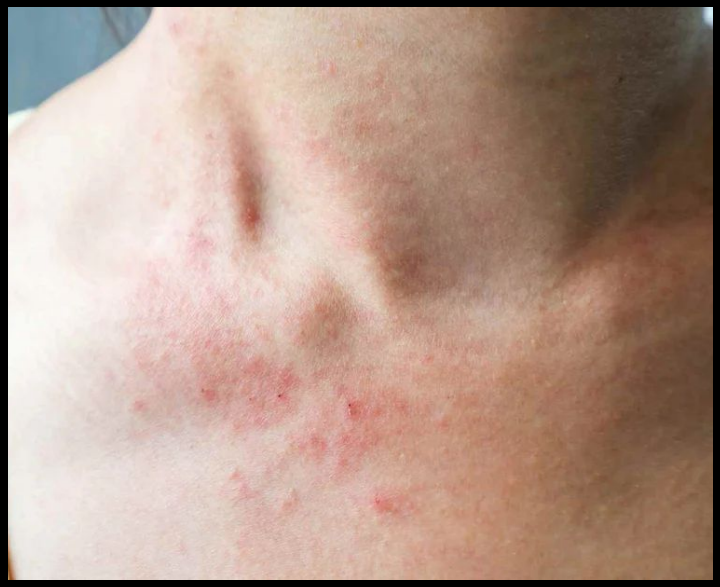
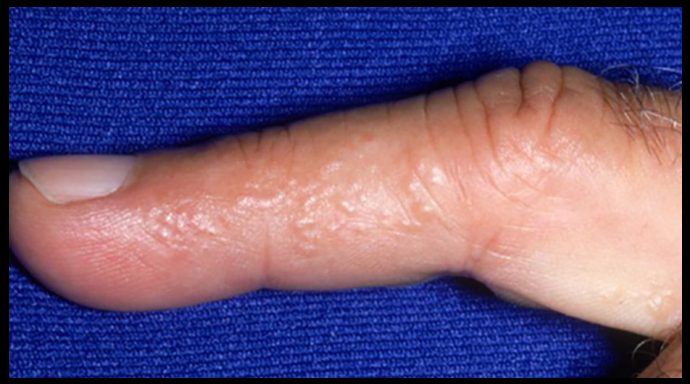




Tina started avoiding all jewelry containing nickel. She makes sure that there is always a barrier between her skin and metal buttons or buckles. She had no rashes for a few years. She started eating more peanut and tree nut products to be healthier. She started developing abdominal discomfort, scattered rashes and itchy blisters on her fingers. Tina likely has:

A. Tree nut allergy
B. Peanut allergy
C. Both A and B
D. Systemic contact dermatitis





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Systemic Contact Dermatitis

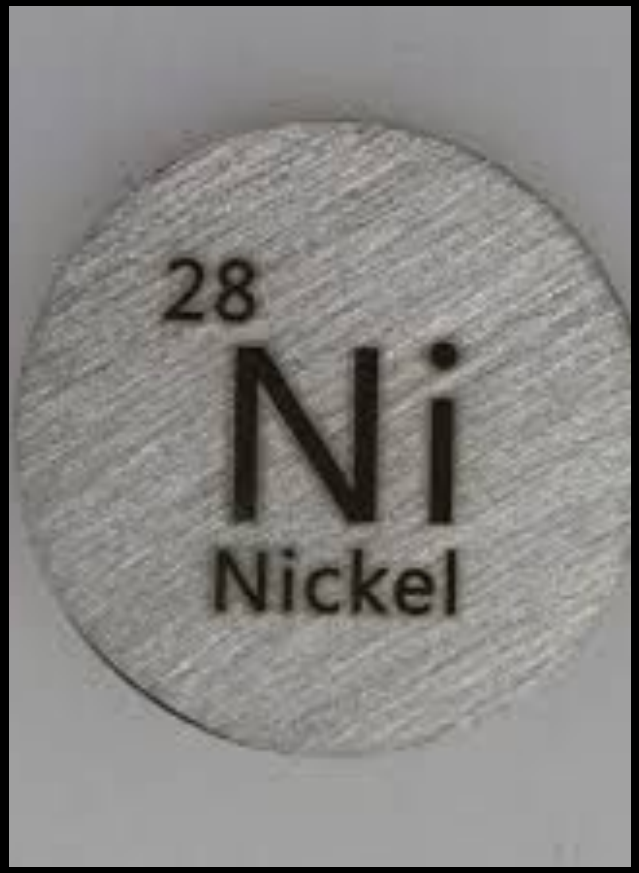
- Occurs with ingestion, intravenous/subcutaneous administration, or inhalation in a previously sensitized patient
- Less common than contact dermatitis caused by direct contact with the skin
- Presents as vesicular hand dermatitis, generalized or diffuse eczematous eruptions, or possible isolated eyelid dermatitis

Top 3 causes of Systemic Contact Dermatitis

- **Nickel**
- **Balsam of Peru (myroxylon pereirae oleoresin)**
- **Propylene glycol**

Nickel

- Natural element
- Commonly found in jewelry, metal buttons, belt buckles, etc.
- Legumes (beans, peanuts, soy) tree nuts, chocolate, oatmeal
- Metal utensils, cooking pots/pans, storage containers
- Medical implants

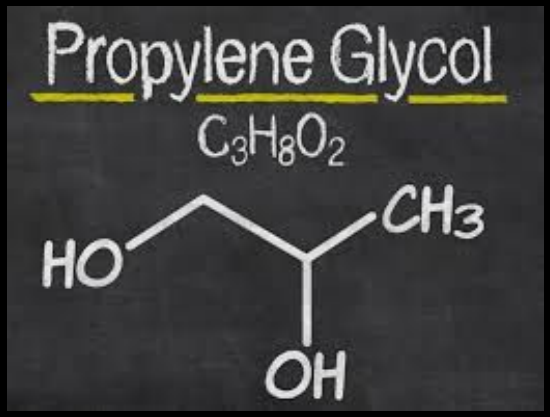


Balsam of Peru

- shampoo/conditioner, topical creams (including medical products), dental medicines/cement, air freshener, lip treatments
- Chocolate, beer, cola, flavored drinks, citrus, ice cream, tomatoes, wine, vanilla, cinnamon, cloves

Propylene Glycol

- Emulsifier, preservative, and excipient
- Added to foods as a humectant and glazing agent
  - Prepackaged bread and flour products, desserts and snacks
  - Ice cream
  - Fast foods and pre-prepared meals
- Topical medicaments (including steroids)
- Oral medicines (including liquid cetirizine, diphenhydramine, and loratadine)



Allergic Contact Dermatitis

Thousands of potential allergens identified

Plants
- Poison ivy, oak, sumac
- Weeds
- Wood

Metals
- Nickel
- Chromium
- Gold

Rubber & plastic agents

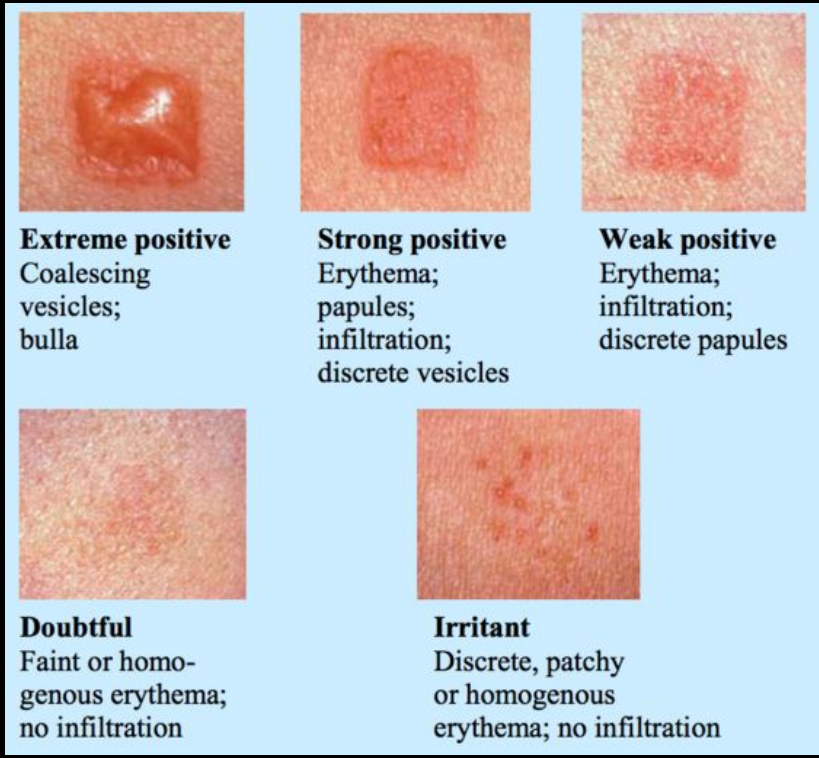
Organic dyes

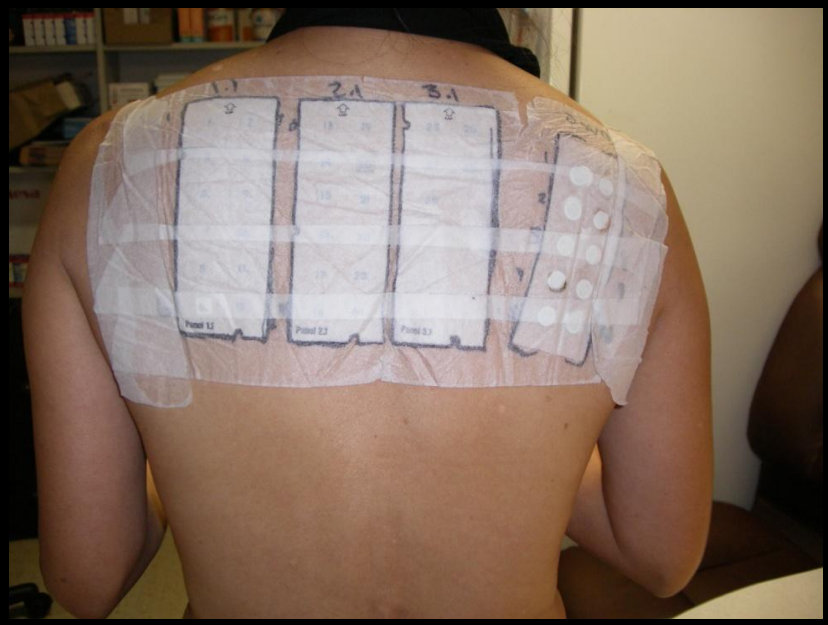
Preservatives
- Thimerosal

Allergic Contact Dermatitis

Diagnosis

- History
- Patch tests





Treatment of Systemic Contact Dermatitis

Avoid the offending allergen, if possible

- Could be in medicines or supplements

- Provide diet information
  - Patient can try avoiding all relevant foods for 3 months
  - If symptoms clear, they may be able to add small amounts into their diets

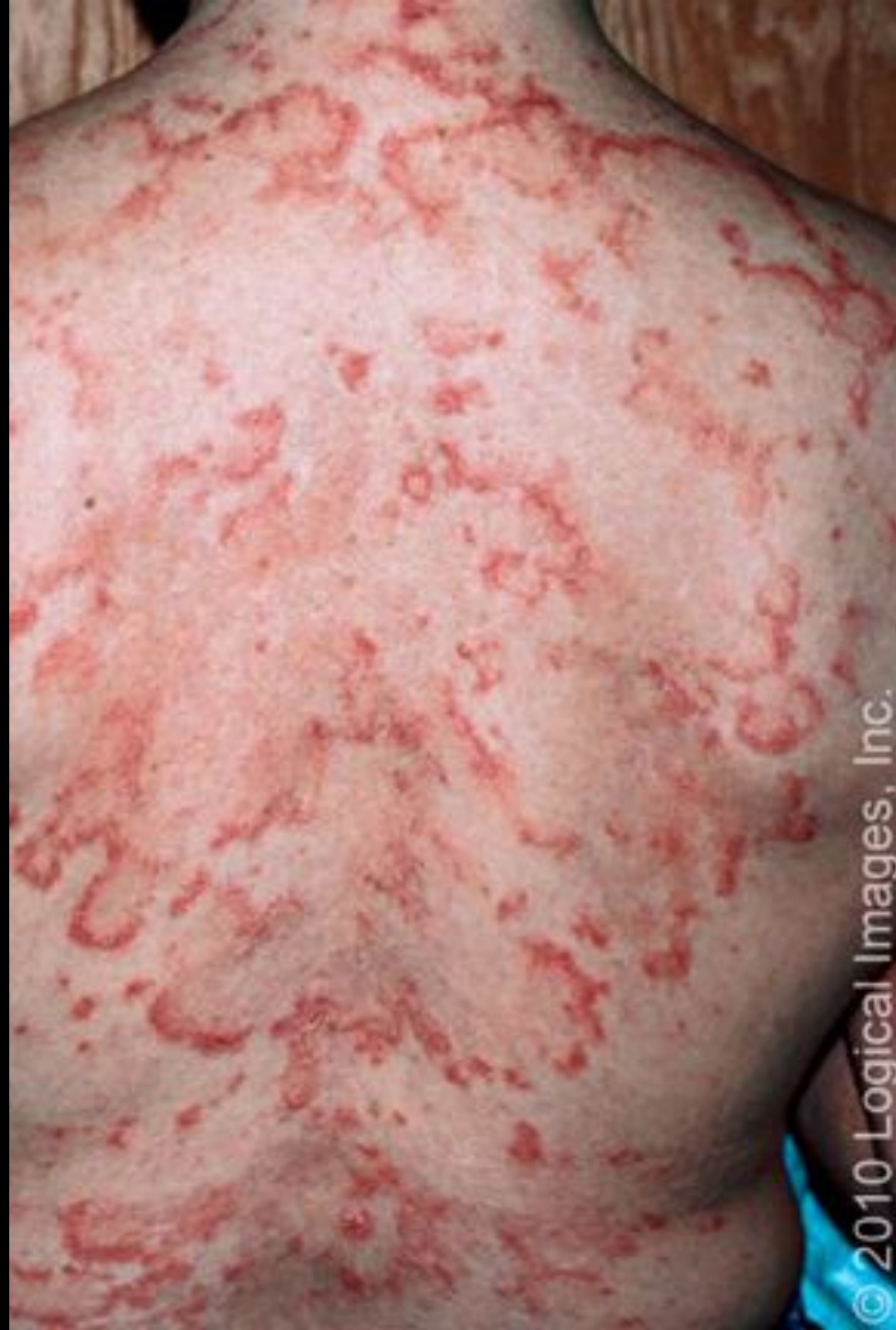
42 yo W is referred to see you for hives. The pictured rash is nonpruritic and does not blanche on exam. You advise the following:

A. An antihistamine regimen

B. Food allergy testing

C. Bleach baths

D. None of the above



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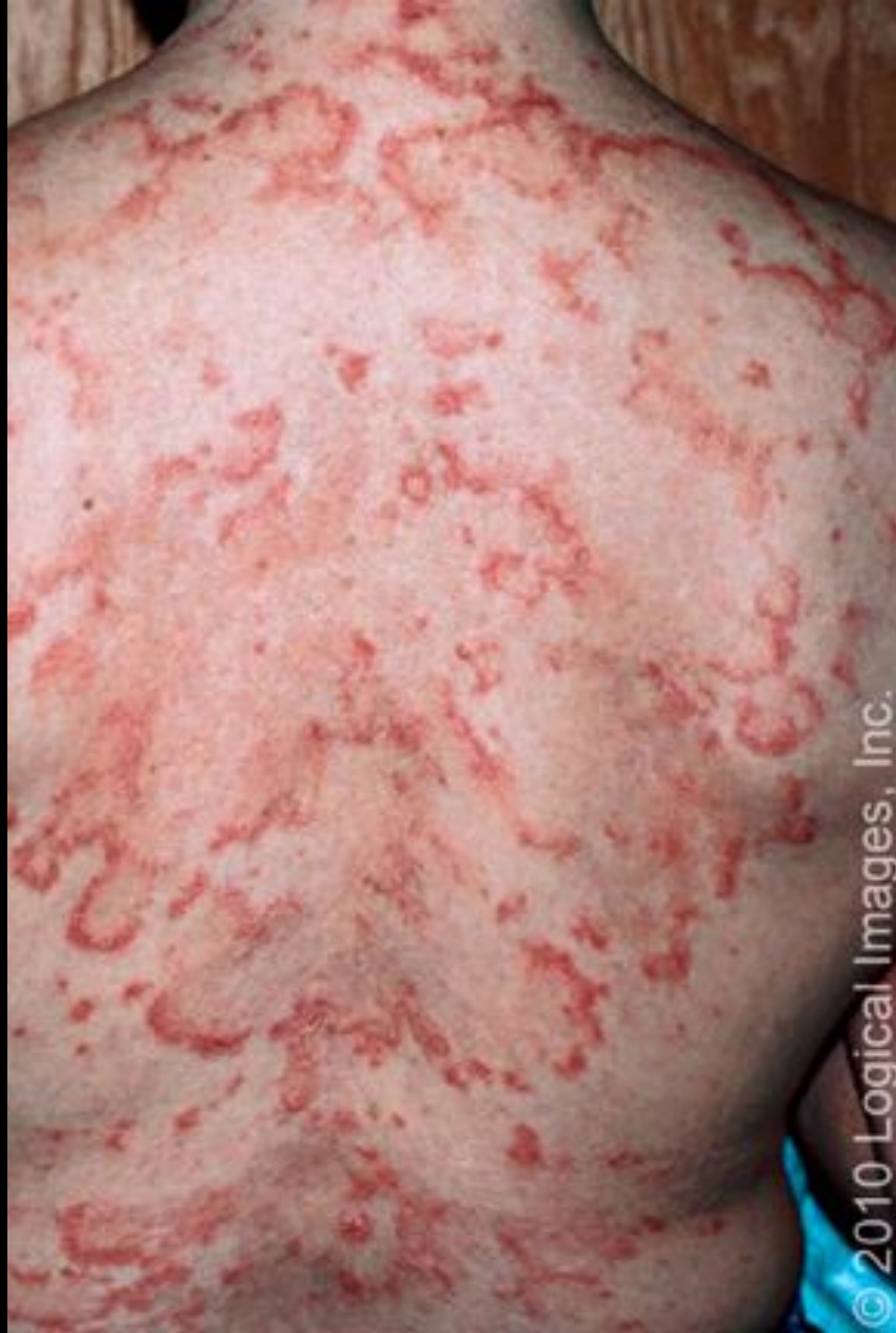
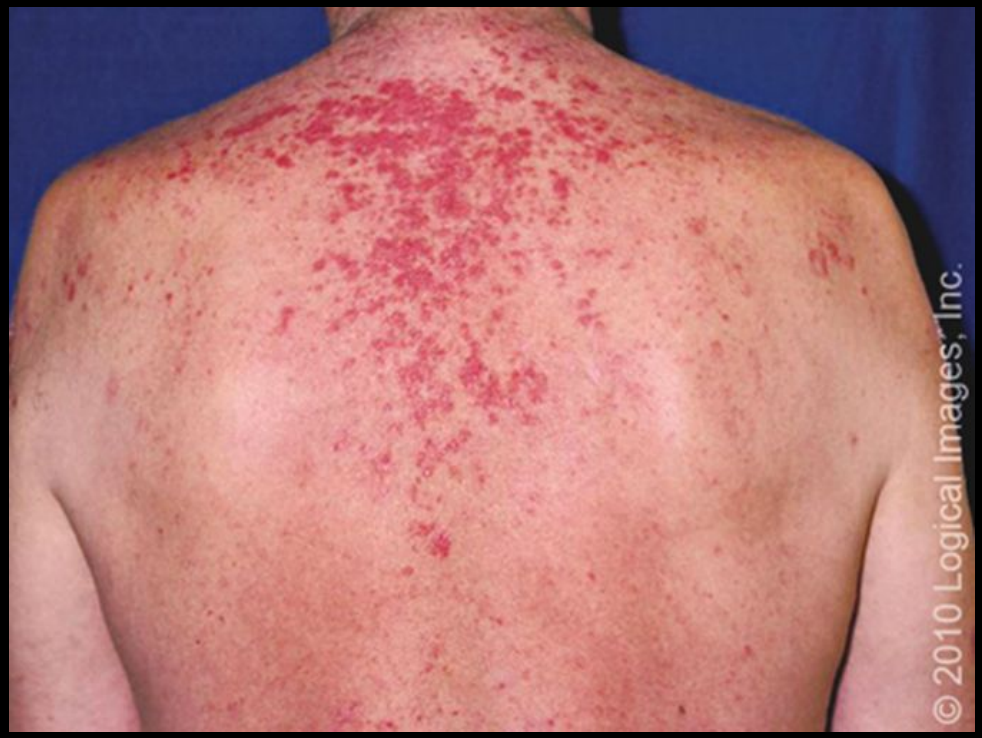


Subacute Cutaneous Lupus Erythematosus (SCLE)

- Most patients have photosensitivity
- 48 to 50% have systemic lupus erythematosus (SLE)
- c. 10 to 15% will subsequently develop SLE
- Can be drug induced



ACE inhibitors (captopril, cilazapril)
Antiarrhythmics (procainamide)
Antiseizure medications (phenytoin, lamotrigine)
Antifungals (griseofulvin, terbinafine)
Antihistamines (cinnarizine/thiethylperazine)
Antineoplastics (docetaxel, paclitaxel, anastrozole, gemcitabine, doxorubicin, tamoxifen, leuprorelin)
Beta blockers (acebutolol, oxprenolol)
Calcium channel blockers (diltiazem, nifedipine, nitrendipine, verapamil)
Diuretics (hydrochlorothiazide, spironolactone)
Immune modulators (leflunomide, interferon-alpha, interferon-beta)
Lipid-lowering agents (pravastatin, simvastatin)
NSAIDs (naproxen, piroxicam)
Proton pump inhibitors (omeprazole, lansoprazole, pantoprazole)
Sulfonylureas (glyburide)
TNF-alpha inhibitors (etanercept, infliximab, adalimumab, golimumab)
Others (D-penicillamine, bupropion, ticlopidine, ranitidine*)

Drugs associated with SCLE


QUESTIONS
Adobe Stock | #430395540