Dyshidrosis and Photoallergic Drug Reaction

August 01, 2003 | Infection [1], Cardiovascular Diseases [2], Skin Diseases [3]

A slightly pruritic, red, scaly rash on an 8-year-old boy's hands has been progressively worsening since it appeared 4 months earlier. Nail pitting also was noted. There are no other rashes on his body. The patient is active in sports; denies any new exposure to soaps, clothing, or other contactants; and spends time in the homes of his recently divorced parents.

What are your thoughts about the cause of the rash?

A. Contact dermatitis.
B. An id reaction to tinea pedis.
C. Tinea manuum.
D. Dyshidrosis.
E. Psoriasis.

What is your initial approach?

F. Prescribe a topical corticosteroid.
G. Prescribe a topical antifungal for the hands.
H. Prescribe a topical antifungal for the hands and feet.
I. Prescribe topical calcipotriol.
J. Perform patch tests.

Case 1: The small vesicles on the palms and on the edges of the fingers (not visible) suggested dyshidrosis, D. However, nail pitting, a characteristic of psoriasis, E, was also present. The psoriasis probably had been exacerbated by the stress of the parents' recent divorce. Thus, the diagnosis was dyshidrosis and psoriasis; the psoriasis manifested as dyshidrosis. Topical calcipotriol, I, and a topical corticosteroid, F, are effective therapies for these disorders.
Antifungal therapy is not helpful; patch testing is not elucidating.
In the absence of nail pitting, a contact dermatitis may be a reasonable consideration. If chronic hand eczema is present, examine the patient's feet. A potassium hydroxide examination can rule out a dermatophyte infection.

**Case 2:** Two weeks after her first course of docetaxel therapy for breast cancer, a 54-year-old woman presents with a pruritic eruption that is confined to sun-exposed areas of her body. The patient has not used new soaps or detergents and has not worn new clothing. She denies excessive sun exposure.

What condition do you suspect caused this eruption?
A. A photoallergic reaction.
B. Cutaneous lupus erythematosus.
C. A polymorphous light eruption.
D. An airborne contact dermatitis.
E. Metastatic carcinoma of the breast.

Your approach is to:
F. Perform a skin biopsy.
G. Recommend a sunscreen effective for UV-A.
H. Prescribe a topical corticosteroid.
I. Prescribe a systemic corticosteroid.

J. Discontinue the chemotherapy.

**Case 2:** It is highly unlikely—albeit remotely possible—for cutaneous lupus erythematosus or a polymorphous light eruption to occur during chemotherapy. Although the distribution and symptoms suggest an airborne contact dermatitis, such a rash usually is more diffuse than this "measles-like" outbreak. Typically, metastatic carcinoma is not pruritic and is not confined to a photodistribution. A skin biopsy, F—which is reasonable under these confusing circumstances—confirmed the clinical suspicion of a photoallergic reaction, A, to the patient's medication. Although photosensitivity is not listed as a potential adverse effect of docetaxel, it is possible for any reaction to occur in any patient at any time.

While awaiting the results of the biopsy, prescribe a UV-A-blocking sunscreen, G—since UV-A is the most common culprit in photosensitive reactions—and a topical corticosteroid, H, for symptom relief. Consult with the patient's oncologist about altering the chemotherapy and before initiating systemic corticosteroids.

**Case 3:**
A painful, papular rash (A and B) erupted on a 60-year-old man 2 weeks after he began taking theophylline for chronic obstructive pulmonary disease (COPD). The medication had been prescribed by the patient's pulmonologist. You are concerned that the rash is a drug-induced vasculitis; you
perform a skin biopsy and obtain a complete blood cell count, liver enzyme levels, erythrocyte sedimentation rate, and a urinalysis. You suggest discussing discontinuation of the theophylline with the pulmonologist, but the patient is not greatly bothered by the eruption and refuses to discontinue the drug.

One week later, the patient returns for biopsy suture removal and diagnosis; his rash is markedly worse (C).

What course of action do you pursue?

A. Discontinue the theophylline immediately.
B. Prescribe a topical corticosteroid.
C. Prescribe a systemic corticosteroid.
D. Repeat the laboratory tests.
E. Consult with the pulmonologist.

Case 3: The initial laboratory test results did not support a diagnosis of vasculitis and yielded no other elucidating information. Theophylline-induced erythema multiforme was diagnosed. The medication was discontinued, A, the pulmonologist was contacted, E, and a systemic corticosteroid was initiated, C. The patient had a complete and uneventful recovery from the cutaneous disorder; the pulmonologist prescribed an agent not related to theophylline for the patient's COPD. A second round of blood tests was unnecessary. Topical corticosteroids have no role in the treatment of erythema multiforme.
**Case 4:** At week 12 of isotretinoin therapy for cystic acne, a 16-year-old girl presents with an acnelike eruption on her extremities that is composed of small, red, itchy bumps atop hair follicles.

Your concerns include:

A. A gram-negative folliculitis.
B. A staphylococcal folliculitis.
C. A yeast folliculitis.
D. Follicular eczema.
E. Exacerbation of acne secondary to isotretinoin.

Which of the following may be relevant to this case?

F. Use of a new soap.
G. The patient has just begun playing soccer.
H. Use of a new fabric softener or detergent.
I. An increase in isotretinoin dosage since the last monthly visit.
J. A new boyfriend.

K. A history of seasonal allergies.

**Case 4:** It is not uncommon for isotretinoin to produce *follicular eczema*, D, in patients with seasonal allergies, K, or other signs of atopy. This occurs most often in the winter months and after an increase in the drug's dosage, I. Using a new soap, F, that is drying also may contribute to the dermatosis. The distribution is not typical of a reaction to detergent or fabric softener. The rough-textured or wool clothing and more frequent bathing often associated with participation in a sport may aggravate the condition, G. As a father, I would immediately implicate a new boyfriend, J, although there is no medical foundation for this.

Bacterial folliculitis usually is more painful than pruritic. Yeast folliculitis is more pruritic and tends to involve the trunk rather than the extremities. Generally, acne is not pruritic, nor does it have a predilection for extremities.

**Source URL:**
http://www.patientcareonline.com/printpdf/dyshidrosis-and-photoallergic-drug-reaction/page/0/1

**Links:**