Clinician Reviews®

Not the Sole Rash on Him

Joe R. Monroe, MPAS, PA

A 47-year-old man first noticed the rash on his right palm about 20 years ago. Since then, it has recurred—usually flaring in the summertime—but has remained largely asymptomatic. The rash manifests with tiny papules, many of which develop into slightly larger blisters that gradually resolve over a period of weeks to months.

Upon questioning, the patient reports that the rash initially manifested shortly after he had joined the military—at which time he also developed a rash on the soles of both feet. Assuming the problem was fungal, he tried applying several OTC creams and even soaked his feet in bleach. Similarly, over the years he has attempted to treat his palmar rash with various prescribed and OTC steroid creams, as well as using OTC topical antifungal creams. None of these efforts have proved fruitful.

The patient claims to be in otherwise good health. He states he is not prone to rashes, seasonal allergies, or sensitive skin.

On examination, the entire right palmar surface is covered by 2-to-3-mm intradermal papules and vesicles, none of which are tender to touch. There is no increased warmth or redness. The dorsal aspect of his hand is totally uninvolved, as are all his fingernails. No notable skin changes are seen on his elbows, knees, or scalp.

KOH examination of the plantar vesicles shows numerous fungal elements, while KOH of the palmar vesicles is negative for fungi.

What is the most likely diagnosis?

a) Two-foot, one-hand disease
b) Dyshidrotic eczema
c) Dermatophytid reaction
d) Contact dermatitis

ANSWER

The correct answer is dermatophytid reaction (choice "c").

DISCUSSION

So-called "id" reactions are usually caused by an infection or inflammatory process occurring at a distant site (a process not well understood). This case repre-

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sents a common manifestation of this phenomenon: a dermatophytid reaction. Other types include "bacterid" and "pediculid."

Dermatophytes are topical fungal organisms that cause dermatophytosis or (in older terminology) "the tineas." This case involves tinea pedis (athlete's foot), a condition that commonly manifests between the toes but can also occur in a "moccasin-variety" form, which affects the rim of the feet. When it flares, the instep can become inflamed; the resulting vesicles, or even pustules, often contain fungal elements that are easily seen on KOH examination.

About 4% to 5% of all fungal infections will trigger an "id" reaction. Other types of ids are not caused by infection, including stasis dermatitis (37% of affected patients develop an id reaction that often manifests with a widespread pruritic rash). When stasis dermatitis is complicated by contact dermatitis (eg, from use of neomycin), an id reaction will develop about two-thirds of the time.

TREATMENT

The causative fungal organism—most likely *Trichophyton rubrum*—should be targeted. In this case, the patient received a month-long course of terbinafine (250 mg/d), as well as a topical miconazole cream to be applied twice daily. Although these treatments cleared the condition, recurrence is still likely. **CR**