Now You See It …

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A 24-year-old Hispanic woman is referred to dermatology for a "fungal infection" that has failed to respond to topical (nystatin) and oral (fluconazole) treatments. The solitary lesion on her palm first manifested several months ago and is totally asymptomatic. Its appearance has fluctuated over time: fading then reappearing, and growing darker each time.

The patient's health is otherwise excellent in almost every regard. Several years ago, she had a bladder infection and was prescribed trimethoprim/sulfa; on the advice of her primary care provider, she continues to take one or two pills after sex to prevent another infection. This is her only prescription medication, but she acknowledges occasional use of OTC products and daily use of vitamins and a stool softener.

Examination reveals a dusky brown patch on the periphery of her left palm. There is no increased warmth or tenderness on palpation, and the lesion is nonblanchable. Palpation of local nodes fails to disclose any suspicious masses near the hand.

Elsewhere, her type IV skin is quite dark but unremarkable.

Given the history and findings, the most likely diagnosis is

a) Tinea nigra
b) Postinflammatory hyperpigmentation
c) Fixed drug eruption
d) Morphea

ANSWER

The correct answer is fixed drug eruption (FDE; choice "c").

Had this been of fungal origin (eg, tinea nigra; choice "a"), there would have been a traceable source, such as a pet or child, and the treatment attempts would have yielded some improvement (although the chosen drugs were not ideal).

In darker-skinned individuals, injuries of all kinds can leave dark skin changes behind (postinflammatory hyperpigmentation; choice "b"), but we had no such history to rely on in this case.

Finally, while morphea (choice "d") may have looked similar, it would have been indurated.

DISCUSSION

FDE is an unusual (but far from rare) reaction to medications—such as sulfa, aspirin, NSAIDs, tetracyclines, or penicillin—that causes round to annular dark macules and patches to appear almost anywhere on the body. "Classic" FDE lesions are targetoid with concentric rings of darker and lighter pigment, but they tend to be morphologically uniform on the palms, lips, and

penis—three areas that FDE particularly favors.

The lesions are unique in that they appear and reappear in the same area(s) each time the patient is challenged with the offending drug. (Chronic use can yield multiple lesions.) In this case, further questioning revealed that the patient had not taken trimethoprim/sulfa for several weeks—but on reflection, she recognized a pattern in the lesion darkening after she did use the medication.

Biopsy can help to confirm the diagnosis. But often, re-challenging the patient with the drug in question is more helpful.

Treatment, of course, entails stopping use of the offending drug. In rare instances, FDE lesions can be blistered and symptomatic—in which case, topical steroid creams can be used to ease discomfort. **CR**