>>DIAGNOSIS AT A GLANCE

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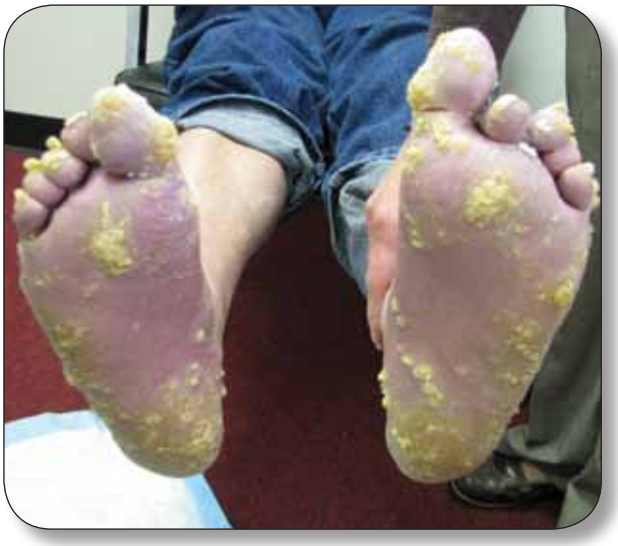
CASE 1

Case submitted by Dr. Schleicher.

A 59-year-old woman seeks consultation for dryness and redness affecting both eyes. The condition has been increasing in severity during the past several months. She is currently taking antihypertensive and lipid-lowering agents. She also uses metronidazole gel for control of rosacea. Examination reveals fairly pronounced conjunctival erythema. Also noted are telangiectasias localized to the malar region of her face.

What is your diagnosis?

CASE 2



Case submitted by Dr. Schleicher and Ms. Frawley.

A 53-year-old man presents with a chronic condition affecting his palms and the plantar surfaces of his feet. The foot disorder has resulted in decreased mobility, and he undergoes mechanical debridement by a podiatrist every 6 to 8 weeks so that he can wear shoes. The condition arose when the patient was in his 20s. Of his five children, three daughters developed a similar problem in their 20s, while his two sons are unaffected. On examination, the plantar surfaces are covered bilaterally with thickened yellowish hyperkeratotic plaques. In addition, the toenails are noted to be thickened and dystrophic.

What is your diagnosis?

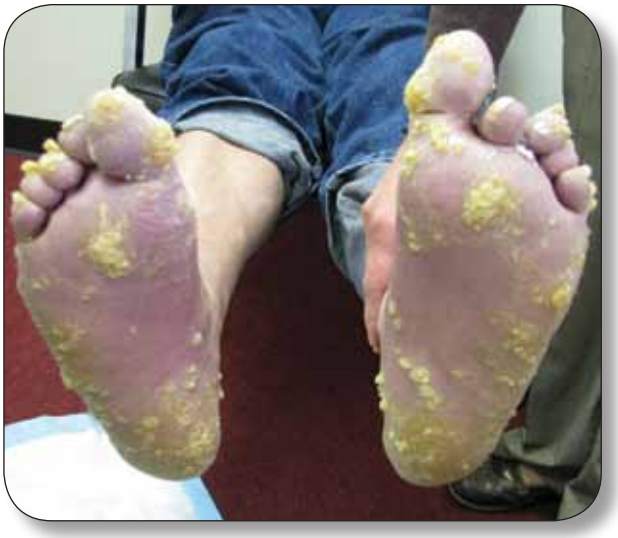
Turn page for answers >>

>> DIAGNOSIS AT A GLANCE CONTINUED

CASE 1

This patient has ocular rosacea, which is characterized by burning, tearing, redness, and a foreign-body sensation affecting the eyes. It is often bilateral. The condition most commonly occurs in female patients ages 50 to 60 who invariably also have facial rosacea. Conjunctival involvement manifests as hyperemia and erythema. Corneal involvement is uncommon but may lead to vision impairment when severe and/or longstanding. The underlying cause of rosacea is believed to be a combination of inflammation and exaggerated vascular response. The treatment of choice is tetracycline or doxycycline, usually requiring administration on a long-term basis.

CASE 2



This patient has keratosis punctata palmaris et plantaris. The condition is inherited in an autosomal dominant manner with variable penetrance. Most cases manifest after age 20. Affected patients may report pruritus, discomfort, or cosmetic disfigurement. There is no cure, and the specific genes responsible have yet to be identified. Management includes use of topical keratolytics such as urea and salicylic acid. Low-dose oral retinoids may also prove helpful. Mechanical debridement is a mainstay of treatment. For severe and refractory cases, total excision of hyperkeratotic skin followed by a skin graft has been successful.

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