Livedo Reticularis and Contact Dermatitis to Poison Ivy

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A network of purplish pink lesions recently developed on a 28-year-old woman’s arms and legs. The asymptomatic rash becomes more prominent with exposure to cold. The patient denies fever, aches, arthralgias, oral erosions, chest pain, and photosensitivity.

Case 1: A network of purplish pink lesions recently developed on a 28-year-old woman's arms and legs. The asymptomatic rash becomes more prominent with exposure to cold. The patient denies fever, aches, arthralgias, oral erosions, chest pain, and photosensitivity.

Which of the disorders in the differential is the likely diagnosis? A. Erythema ab igne.
B. Livedo reticularis.
C. Cutis marmorata.
D. Raynaud phenomenon.

Which of the following disorder(s) is associated with this patient's skin condition? E. Hepatitis C.
F. Lupus erythematosus.
G. Pancreatitis.
H. Minocycline hypersensitivity.
I. Syphilis.

Case 1: Livedo reticularis, B, is characterized by a mottled pattern of reddish blue macules that are attributed to sluggish blood flow through the reticular blood vessels. The disorder is associated with a variety of conditions, including hepatitis C, E; lupus erythematosus, F; pancreatitis, G; minocycline hypersensitivity, H; and syphilis, I.

Erythema ab igne is caused by prolonged exposure to a heat source, such as a hot water bottle; the initial erythema gives way to brown hyperpigmentation of the affected skin. The mottling of cutis marmorata, which is seen in neonates, is transient and can disappear when the skin is warmed. In patients with Raynaud phenomenon, cold or emotional stimuli can produce ischemia of the toes and fingers that is often associated with paresthesia and pain of the affected digits.

Although this patient's antinuclear antibody level was elevated, it fell short of the criterion for a connective tissue disorder. She is being followed closely for additional signs of lupus erythematosus or other underlying disease.

Case 2:
A 44-year-old man presents with a progressively worsening itchy lesion on the arm that has become a painful, draining plaque during the past 12 days. An injection of methylprednisolone acetate, oral ampicillin, and oral diphenhydramine hydrochloride given in the emergency department 1 week earlier failed to resolve the lesion. The patient is otherwise healthy and enjoys doing yard work. Can you identify the lesion? A. Poison ivy rash with secondary bacterial infection.

B. Brown recluse spider bite.
C. Black widow spider bite.
D. Gram-positive bacterial cellulitis.
E. Factitial dermatitis.

Your treatment plan includes . . . F. A second injection of methylprednisolone acetate.
G. An injection of triamcinolone acetonide.
H. A different antibiotic, such as cephalexin.
I. A systemic antifungal agent.
J. A protective wrap placed over the arm to prevent exacerbation of the suspected self-inflicted lesion.

Case 2: The patient had a contact dermatitis, most likely poison ivy, contracted while gardening, with a secondary bacterial infection. A. Spider bites and cellulitis are not initially pruritic; the patient’s history did not support a factitial dermatitis. The corticosteroid he received is more appropriate for chronic conditions, such as arthritis; methylprednisolone acetate is not adequate therapy for acute skin problems. The prescribed antibiotic, oral ampicillin, did not cover the secondary staphylococcal infection, which was provoked by intense scratching of the pruritic poison ivy. Diphenhydramine hydrochloride can ameliorate pruritus, but it plays no role in the treatment of poison ivy. Intramuscular triamcinolone acetonide, G, and a cephalosporin, H, produced dramatic improvement within 2 days.

Case 3: A 29-year-old woman has had asymptomatic red spots on her upper trunk for 2 weeks. She complains that the lesions appear to be spreading. The patient takes no medication and denies exposure to the sun.

What are you looking at here? A. Urticaria.
B. Pityriasis rosea.
C. Tinea versicolor.
D. Drug eruption.
E. Mycosis fungoides.

Which of the following do you offer the patient? F. Reassurance only.
G. An antifungal cream.
H. A systemic antifungal agent.
I. A tapered dosage of prednisone.
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J. A corticosteroid cream.

Case 3: A potassium hydroxide (KOH) examination of a scraping of fine scale from a lesion confirmed the diagnosis of tinea versicolor. The variety of colors of the presenting lesions gives this yeast infection its name; macules or patches may be hyperpigmented or hypopigmented and manifest as white, pink, or brown lesions. Typically, urticaria lasts for hours, not days or weeks. Pityriasis rosea was ruled out by the KOH evaluation. The patient’s history did not support a drug eruption. Mycosis fungoides’ psoriasis-like eruption with atrophy and telangiectasia most commonly arises on the lower trunk, buttocks, and thighs; tinea versicolor is most prominent on the upper trunk. Vitiligo is often included in the differential of black-skinned patients with hypopigmented tinea versicolor lesions; a KOH examination will confirm the fungal infection. Oral antifungal therapy, H, is often more effective than topical agents. Systemic drugs may be better able to eradicate the yeast and forestall recurrences, which are not uncommon.

Case 4:
For several weeks, a 34-year-old woman has had a pruritic rash under her breasts. She also complains of itching; slight redness; and scale in the groin area, eyebrows, and nasolabial folds. The patient has type 2 diabetes mellitus, which is well controlled with glipizide. Which disorder in the differential is the likely diagnosis? A. Seborrheic dermatitis. B. Psoriasis. C. Contact dermatitis. D. Diabetic dermopathy. E. Candidiasis.


J. Prescribe an over-the-counter antifungal powder.

Case 4: A potassium hydroxide examination, G, ruled out a fungal infection and thus supported the diagnosis of seborrheic dermatitis, A. This erythematous, scaling rash arises in a seborrheic distribution, which involves the eyebrows, eyelids, nasolabial folds, ears, scalp, mid chest and, less commonly, the axillae, umbilicus, and groin. Psoriasis can occur secondary to the inflammation caused by seborrhea (the Koebner phenomenon) but was unlikely here because of the absence of nail pitting, H, or other characteristic changes. The distribution was not typical of a contact dermatitis, which is usually seen on exposed areas and is much more pruritic, or a Candida infection, which is more crusty and features satellite lesions. Diabetic dermopathy is characterized by brown macules that overlie the shins and is often seen in persons with diabetes. This patient’s history of
diabetes was not relevant to her cutaneous disorder.

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