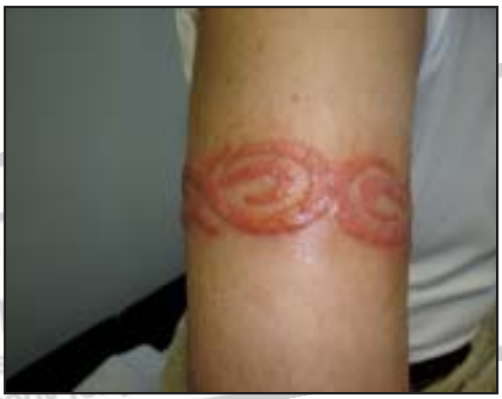
Case 1

Tattoo Trouble!

While in the Dominican Republic, this 30-year-old man had a non-permanent tattoo applied to his deltoid area. Two days later, the area was itchy and exudative.



What is the diagnosis?

a. Reaction to henna dye
b. Reaction to para-phenylenediamine
c. Secondary infection
d. Berloque dermatitis
e. Photo reaction to the dye

Answer

Henna is a plant dye derived from a shrub. It has been used for centuries in hair dyes and skin decorations to give a reddish colour which disappears over weeks.

As henna is a weak sensitizer, reactions to henna dyes are usually due to the admixture of *para-phenylenediamine (PPD)* (**answer B**). PPD added to henna gives a brown-black colour and decreases the fixing time of the henna tattoo.

Treatment requires both oral and topical steroids with almost a month for the reaction to resolve. The patient is also advised to avoid all permanent dye products containing PPD.

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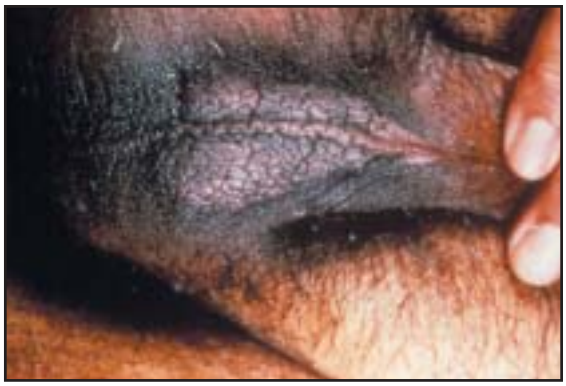
This month—4 cases:

1. *Tattoo Trouble!*
2. *Easing the Itch*
3. *"Why's my face all patchy?"*
4. *"My hair's falling out!"*

Case 2

Easing the Itch

A 43-year-old male patient presents with a chronic itch on his scrotum. He has been scratching this lesion.



What can it be?

a. Lichen planus
b. Lichen simplex chronicus
c. Psoriasis
d. Tinea corporis
e. Bowen's disease

Answer

This patient has *lichen simplex chronicus* (LSC) (**answer b**), otherwise known as neurodermatitis circumscripta.

LSC is a localized, chronic pruritic disorder resulting from repeated scratching and rubbing. It is characterized by the resulting lichenified, pruritic circumscribed plaques.

The occiput, elbows, wrists, anogenital areas, anterior tibia and ankles are common sites. Multiple sites may be involved.

Clues differentiating LSC from psoriasis include a lack of silvery scaling, asymmetrical distribution and increased skin markings.

A biopsy is necessary when lesions do not clear with topical or intralesional therapy and may help rule out inflammatory or neoplastic conditions.

The treatment goal is to break the itch-scratch-lichenification cycle. Educate the patient on the importance of avoiding scratching. Recurrence is frequent and multiple treatments with different modalities may be required. These include high-potency topical steroids, occlusive plastic film, flurandrenolide tape and intralesional steroids.

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Case 3

"Why's my face all patchy?"

A 34-year-old female presents complaining of hyperpigmented patches on her face. She has been feeling less confident lately and would like to know if the pigment will go away.

She is currently taking an oral contraceptive pill. Her thyroid and liver function tests are normal.

What are the exacerbating factors?

a. Pregnancy
b. Ultraviolet radiation
c. Oral contraceptives
d. Phenytoin
e. All of the above

Answer

This patient has melasma ("chloasma" or "the mask of pregnancy"). Along with post-inflammatory hyperpigmentation, melasma is the most common pigmentation disorder for which patients seek treatment. Typically, there is macular hyperpigmentation on sun-exposed areas of the face that are usually symmetrical with an irregular border.

The etiology is unknown, but it may be due to elevated estrogen states, such as during pregnancy or the use of oral contraceptives. It is aggravated by many factors (**answer e**).

Our patient was advised that, although her melasma may persist as long as oral contraceptives are taken, there are ways to help reduce pigmentation.

Hydroquinone helps reduce skin pigmentation by blocking melanin production and causing direct melanocyte injury. If the pigment is dermal (*i.e.*, blue to grey colour) the condition is much more difficult to treat.

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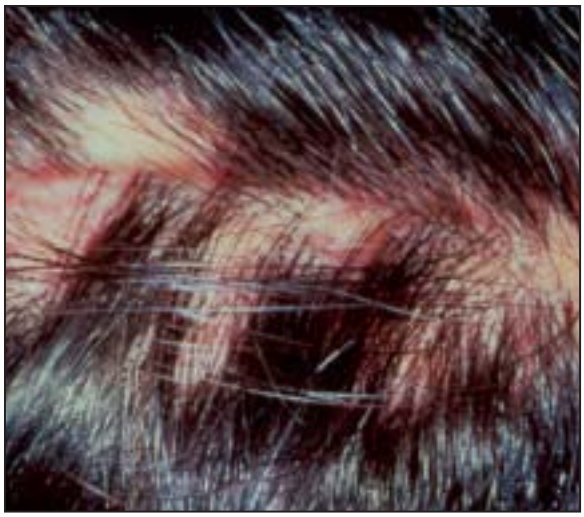
Case 4

"My hair's falling out!"

A 38-year-old woman presents complaining of an area of hair loss on her scalp. Follicles are not visible and scarring is present.



What do you think?

a. Lichen planopilaris
b. Discoid lupus erythematosus
c. Alopecia areata
d. Pseudopelade
e. Folliculitis decalvans

Answer

This woman has *lichen planopilaris* (**answer a**). Lichen planopilaris is a primary cause of scarring alopecia and a clinical syndrome of lichen planus. It is a dermatosis of unknown etiology and is more common in women than men.

Lesions consist of patchy hair loss with perifollicular erythema, follicular spines and scarring. Eventually, scars that are devoid of hair form little resemblance to the active disease—these are areas of atrophy, scarring and permanent hair loss. Lesions may persist for 18 months, with some resolving spontaneously and others persisting for years.

Treatment consists of antimalarials, antibiotics and topical, intralesional and oral corticosteroids. Oral antihistamines can control pruritis. More difficult cases may require systemic retinoids, cyclosporine or low-dose weekly oral methotrexate.

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