"What are these itchy spots?"

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A 65-year-old woman presents with a two-week history of coin-shaped, itchy, scaly plaques on her lower extremities. She reports having experienced similar lesions the previous winter. She is otherwise healthy. There has been no treatment to date.

What is your diagnosis?

Nummular ("coin" in Latin) dermatitis is a type of eczema characterized by intensely itchy, oval-round, scaly plaques typically located on the upper and lower extremities. It is a chronic condition that waxes and wanes over time. The lesions evolve from small papules or vesicles into prototypical, coin-shaped plaques measuring several millimeters to several centimeters in diameter. The surface of the plaques often appears dry and cracked.

The condition commonly presents in the elderly population especially during the cold, dry winter months but can also appear in younger atopics in the second or third decade of life. There is no racial or sex predilection. The etiology is unknown and is likely multifactorial; however, excessive dry skin may be a predisposing factor. Bites, trauma, burns or contact allergen exposure may precede an outbreak of nummular dermatitis. The plaques typically heal without consequence, but can result in post-inflammatory hyperpigmentation especially in dark-skinned individuals.

The differential diagnosis of nummular dermatitis includes:

- tinea corporis,
- psoriasis,
- impetigo,
- mycosis fungoides and
- Bowen's disease.

The diagnosis of nummular dermatitis is clinical. A bacterial culture swab can be performed if secondary infection is suspected. A skin scraping for potassium hydroxide examination or fungal culture would rule out dermatophytosis. Although rarely performed, a biopsy would be helpful in distinguishing it from psoriasis and malignancies, such as Bowen's disease and mycosis fungoides.

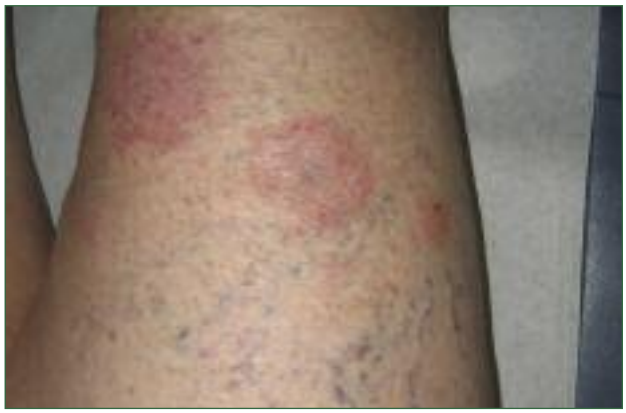

Figure 1. Coin-shaped, itchy, scaly plaques.

Unfortunately, there is no cure for nummular dermatitis. Maintaining adequate skin hydration with emollients and room humidifiers is paramount as is avoiding excessive hot water bathing, harsh soaps and irritating wool clothing. Topical corticosteroids are usually the mainstay of treatment while topical and oral antibiotics can be utilized if there is evidence of secondary infection. If the condition fails to respond to a four-week trial of mid- to high-potency topical corticosteroids, a dermatologist referral would be advisable. Phototherapy, systemic steroids and cyclosporine have been used in recalcitrant cases.

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Dr. Gupta completed his Dermatology Fellowship training at Harvard University and currently practices in Toronto, Ontario with a special interest in Laser Dermatology.