

Itchy rash with grouped vesicles

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A man presents with a persistent papulovesicular rash on his limbs, trunk and face. What is the diagnosis and how can this condition be treated?

A 45-year-old man gave a five-year history of an extremely pruritic rash which was generalised and associated with itchy, grouped vesicles and papules that were excoriated. The rash was particularly prominent over the extensor surfaces of the limbs, but it was also present on the trunk (Figure 1) and face. A skin biopsy showed a subepidermal blister with intense neutrophilia at its base forming small subepidermal microabscesses (Figure 2). Direct immunofluorescence of some perilesional skin revealed granular deposits of IgA in the subepidermal zone (Figure 3).

Differential diagnosis

A number of dermatoses need to be considered for this presentation.

- **Scabies** is associated with intense itching that is often worse at night. The face is usually spared and genital involvement is usually present. Close examination often reveals scabies burrows (particularly on the wrists and sides of the fingers) which can be scraped to confirm the diagnosis.
- **Papular eczema or nummular dermatitis** may present as a patchy dermatitis

that is particularly concentrated on the limbs. In chronic cases, firm excoriated papules may emerge (prurigo papules). Acute cases may have grouped vesicles. Skin biopsy shows intraepidermal vesicles containing lymphocytes and eosinophils.

- **Dermatitis herpetiformis** is the correct diagnosis. The term herpetiformis is used to describe the grouped vesicles that may be seen, but these are not due to herpesvirus. The initial lesions in dermatitis herpetiformis may be particularly prominent on the elbows and knees. Haemorrhagic vesicles may develop on the hands. Early lesions may appear as urticarial papules. Mucous membrane lesions are rarely observed. Skin biopsy shows papillary microabscesses and subepidermal blisters, and the presence of IgA in a granular pattern in the dermal papillae is diagnostic.

Most patients with dermatitis herpetiformis have a gluten-sensitive enteropathy, which is usually asymptomatic. Long term gluten-free diets may help to resolve the skin lesions. Most cases are managed with dapsone (Dapsone 100) 50 to 200 mg daily or sulfapyridine (Dagenan, MB 693) 1 to 2 g daily. Occasionally, prednisone (Panafcort, Sone) or colchicine (Colgout) may be added in resistant cases. Haemolytic anaemia, leucopaenia, methaemoglobinaemia and rarely agranulocytosis or peripheral neuropathy may develop with dapsone therapy and close laboratory monitoring is required.

Keypoint

A persistent, symmetrical papulovesicular eruption that fails to respond to topical therapy may represent dermatitis herpetiformis. Skin biopsy or immunofluorescence is required for definitive diagnosis.

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Figure 1. Extensive grouped, excoriated papulovesicular rash on the back.

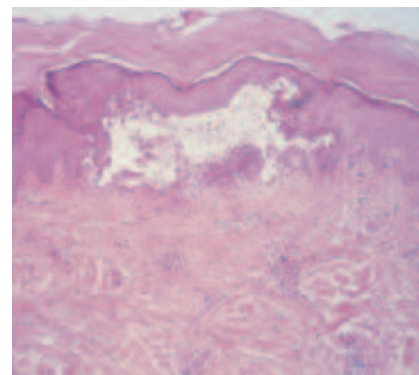


Figure 2. Skin biopsy showing a subepidermal blister and intense neutrophilia in the papillary dermis.

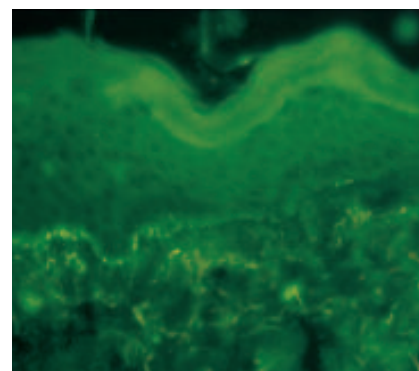


Figure 3. Immunofluorescence revealing granular deposits of IgA in the papillary dermis below the epidermis.