



## CASE REPORT ON DISSEMINATED ECZEMA WITH CRYSTAL PLAQUES

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### ABSTRACT

Disseminated eczema is a type of dermatitis developing days or weeks at skin locations distant from the initial inflammatory or infectious site. They may be localised or generalised. It is an skin infection characterised by scaly, itchy lesions with reddish colour which may be localised or all over the body. Forearms, lower legs, thighs and trunk are commonly affected. Appearance varies and includes blisters, bumps, crusted plaques (discoïd eczema), follicular papules, morbilliform eruption, targetoid lesions and pompholyx (blisters on palms and soles). Left untreated may become infected with bacteria. Disseminated eczema or id reaction can be treated through a combination of antihistamines, Topical medications, and oral medications. The prognosis is typically productive with suitable treatment, also the outcome depends upon the primary reason for eczema.

### INTRODUCTION

Disseminated eczema (also known as id reactions, generalised eczema, autosensitization dermatitis) is an acute generalised eczema/ dermatitis that arises in response to a prior localised inflammatory skin disease. Id reaction is generalized itching that appear not only on the 'specific' affected area, but all over the body. The cause of this eczema is unknown, but it may be due to an autoimmune reaction of the body to the underlying cause of primary itching[1]. The contributory factors for disseminated eczema may include infections, insect bites, and some other forms of eczema.

Disseminated secondary eczema can occur in children and adults, but more often diagnosed in the elderly with a neglected primary rash on the lower leg[2]. The most common types of eczema / dermatitis that may follow after disseminated secondary eczema are chronic venous eczema, acute contact eczema, acute or chronic discoïd eczema. The clinical features of disseminated eczema include extreme itching, disturbed sleep, blisters, bumps, crusted plaques (Discoïdeczema).Follicular papules, morbilliform eruption, targetoid lesions may appear[3]. Apart from generalized itching all over the

body, the condition may cause loss of appetite, fever. Disseminated eczema is often an under diagnosed condition. The diagnostic tools may include skin culture for various infections, KOH test, allergy skin testing for other skin disorders, and a biopsy to trace out similar conditions[4]. The primary rash needs to be treated vigorously. This may require systemic therapy like antibiotics for bacteria or oral antifungal for confirmed dermatophytid. ID Reaction can be treated through a combination of antihistamines, topical applications, and oral medications. The prognosis is typically excellent with suitable treatment, though the outcome also depends upon the primary reason for disseminated eczema[5].

### CASE STUDY:

A 46 y/o male patient was admitted in dermatology ward with chief complaints of itchy lesions over bilateral hands, legs since 10 days. He had a past history of itching in vesicles and oozing history after exposure to cotton fibres 8 years back. There is no history of any fever, joint pains and drug exposure. Diabetes

patient taking Metformin twice a day and there is no history of hypertension and asthma. There is no similar family history. Immunization of the patient was up to age with scheduled intervals. The patient was non alcoholic and a teetotaler. On examination the patient is conscious and oriented. Cutaneous examination revealed multiple

vesicles and plaques present over the bilateral legs, bilateral arms, trunk oozing in nature and crusted plaques over left leg, white plaques over tongue. Physical appearance of crusted plaques and disseminated erythematous eczema are given in the figure 1, 2 and 3.

**Table 1. Lab Investigations:**

Parameter	Observed value	Normal value
Blood urea	27mg/dl	15-45mg/dl
Serum creatinine	0.9mg/dl	0.8-1.6mg/dl
Serum electrolytes		
Sodium	149mmol/l	134-144mmol/l
Potassium	6.9mmol/l	3.5-5.5mmol/l
Chloride	86mmol/l	98-102mmol/l
Hemoglobin	12g/dl	12-14g/dl
Total count	9,600cells/cumm	5000-10,000/cumm
RBC	4.73million cells/micro lt	4.5-5.5millioncells/micro lt

**Figure: 1. Physical appearance of disseminated eczema over forearm**



**Figure: 2. Erythematous lesions over abdomen**



**Figure: 3. Crusted plaques over left lower limb**



**DISCUSSION**

By the presence of multiple vesicles and plaques present over the bilateral legs, bilateral arms, trunk oozing in nature and crusted plaques over left leg, it was diagnosed as disseminated eczema. According to American academy of dermatology, the patient was prescribed with Tab. Amoxicillin 500mg + clavulanic acid 125mg thrice a day, tablet fluconazole 150 mg once a day, tablet Cetrizine 10mg once daily, Fusidic acid cream as a topical application.

**Other drugs that can be prescribed for this condition are:**

- Fluocinonide ointment 0.1%
- Antihistamines such as Diphenhydramine 25-50mg helps to control itching.

Corticosteroids help lesion resolution and provide symptomatic relief of eczema. The strength and administration of a topical corticosteroid should be chosen

based on the extent, location and morphology of the eruption.

The patient was counselled with life style modifications like wear loose fitting cotton blend clothing, keep fingernails smooth and short to avoid damage due to scratching, maintain hygienic conditions, take medications regularly.

**CONCLUSION:**

Disseminated eczema is frequently unresponsive to corticosteroids therapy, but clear when the focus of infection or infestation is treated. Therefore, the best treatment is to treat the provoking trigger. Sometimes medications are used to relieve symptoms, These include topical corticosteroids, and antihistamines. If opportunistic bacterial infection occurs, antibiotics may be required. A full recovery is expected with treatment. Recurrent eczema is frequently due to inadequate treatment of the primary infection or dermatitis and often the cause of recurrence is unknown.

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