Dermatology Inpatient Hot Cases

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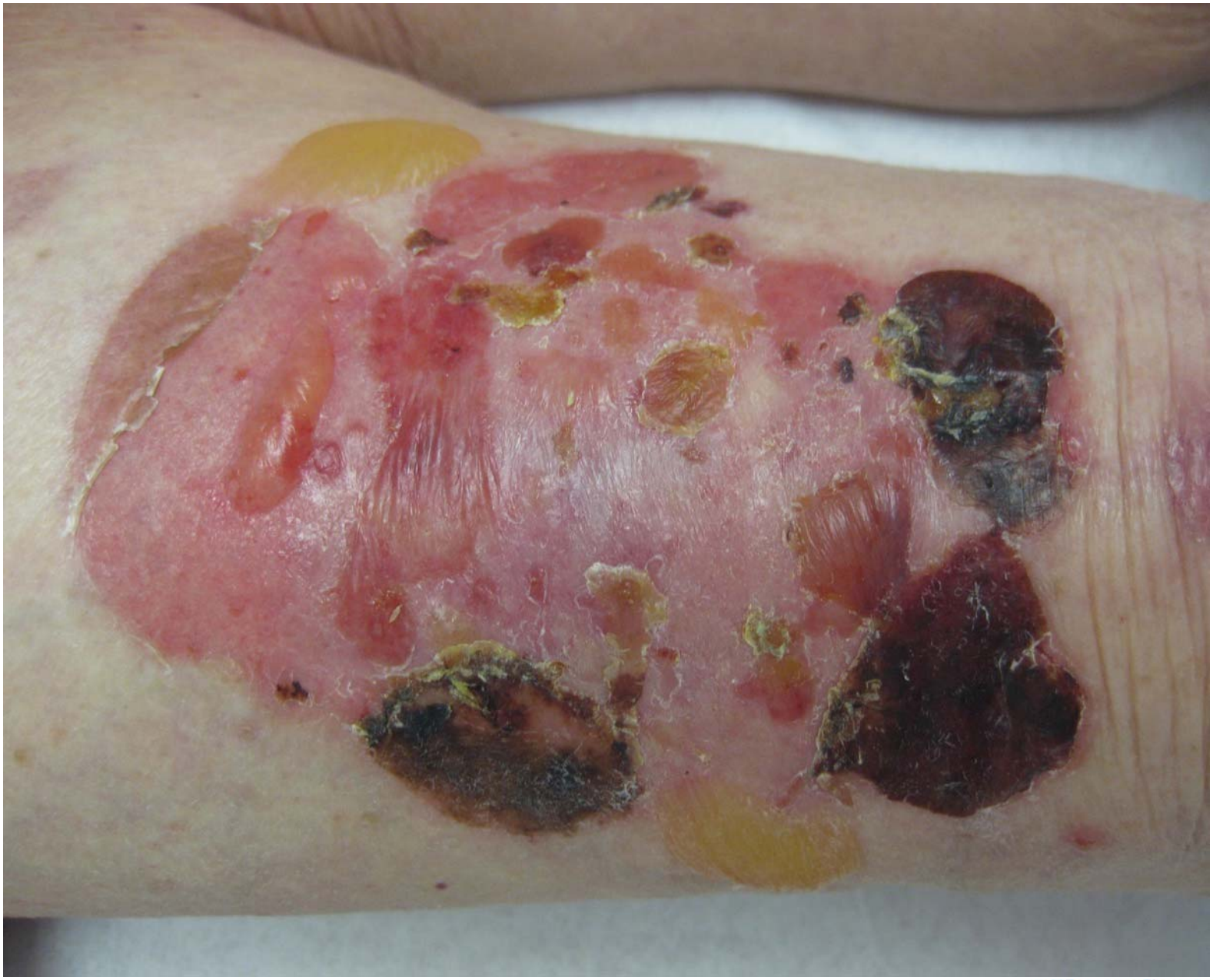
NO DISCLOSURES



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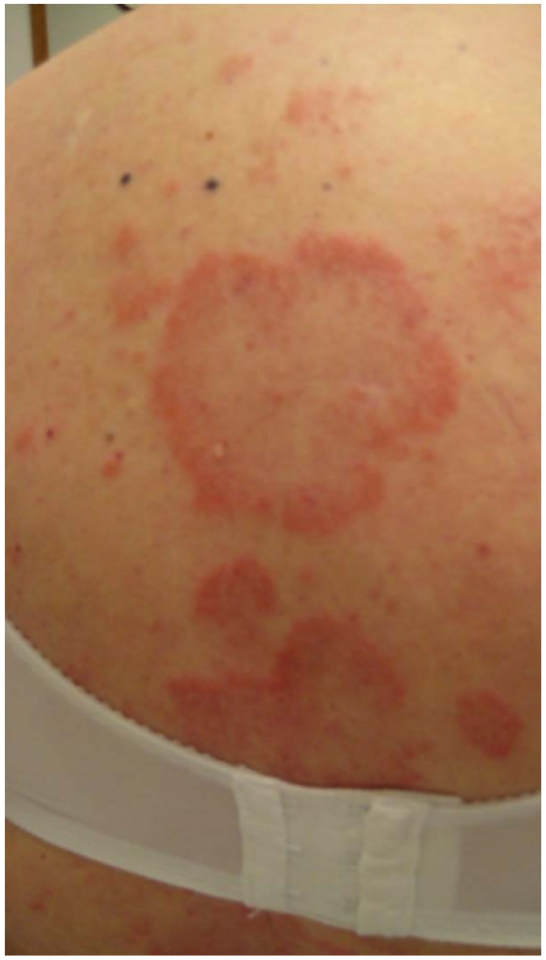
All of the following can be used to treat this condition except?

- A. Prednisone
- B. Doxycycline
- C. Niacinamide
- D. Captopril
- E. Mycophenolate Mofetil

D. Captopril

Consult for dermatitis



What medications can cause SCLE?

A. Terbinafine
B. Griseofulvin
C. Hydrochlorothiazide
D. Calcium channel blockers
E. All of the above

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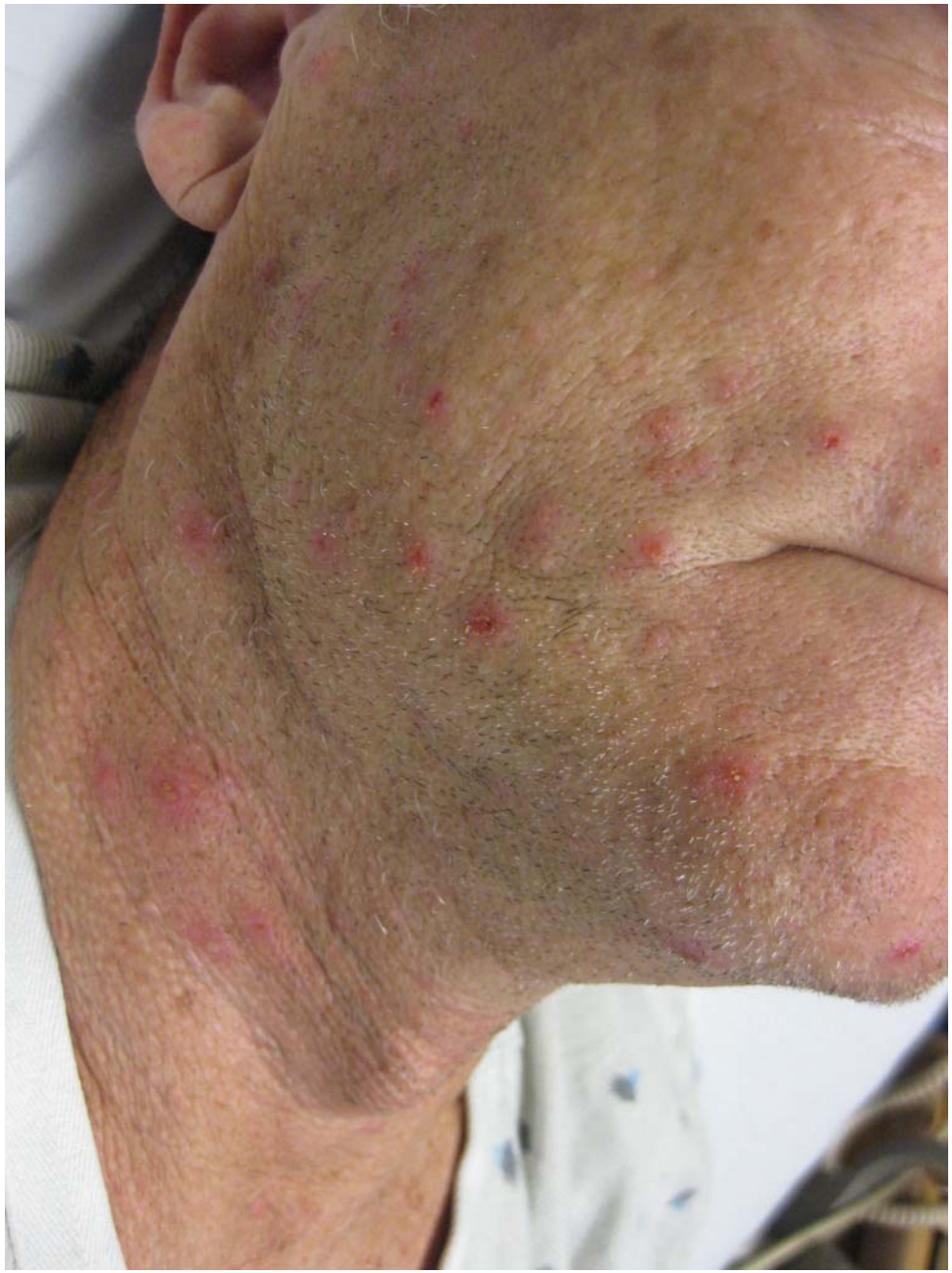

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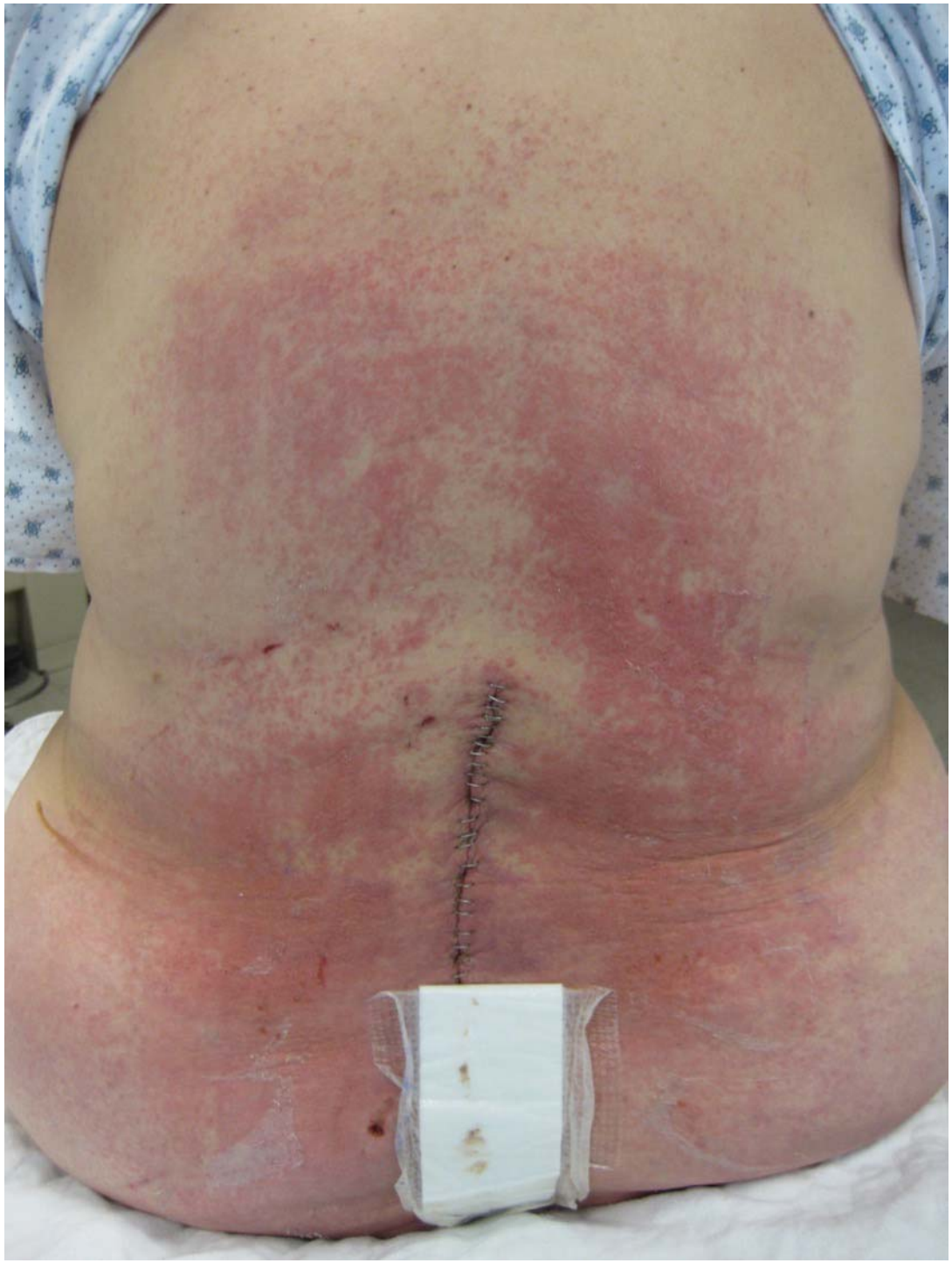
Importance of histopathology

- HSV is negative
- **VZV stain is strongly positive**.
- Neither fungal microorganisms nor basement membrane changes are seen with interpretation of PAS histochemical stain.
- GMS and gram stains are negative for micro-organisms.



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Rosin (Colophony)-irritant contact dermatitis

- Found in adhesive tape, cosmetics, insulating tape, glossy paper, flypaper, polish, paints, inks, epilation wax,rosin bags for baseball players, varnishes, violin bows, chewing gum
- From *Pinus palustris* and *Pinus caribaea* (conifers)
- A.k.a. abietic acid

Atopic dermatitis

Atopic dermatitis is associated with all except:

A. Psoriasis
B. Central facial pallor
C. Pityriasis alba
D. Nipple eczema
D. Hyperlinear palms

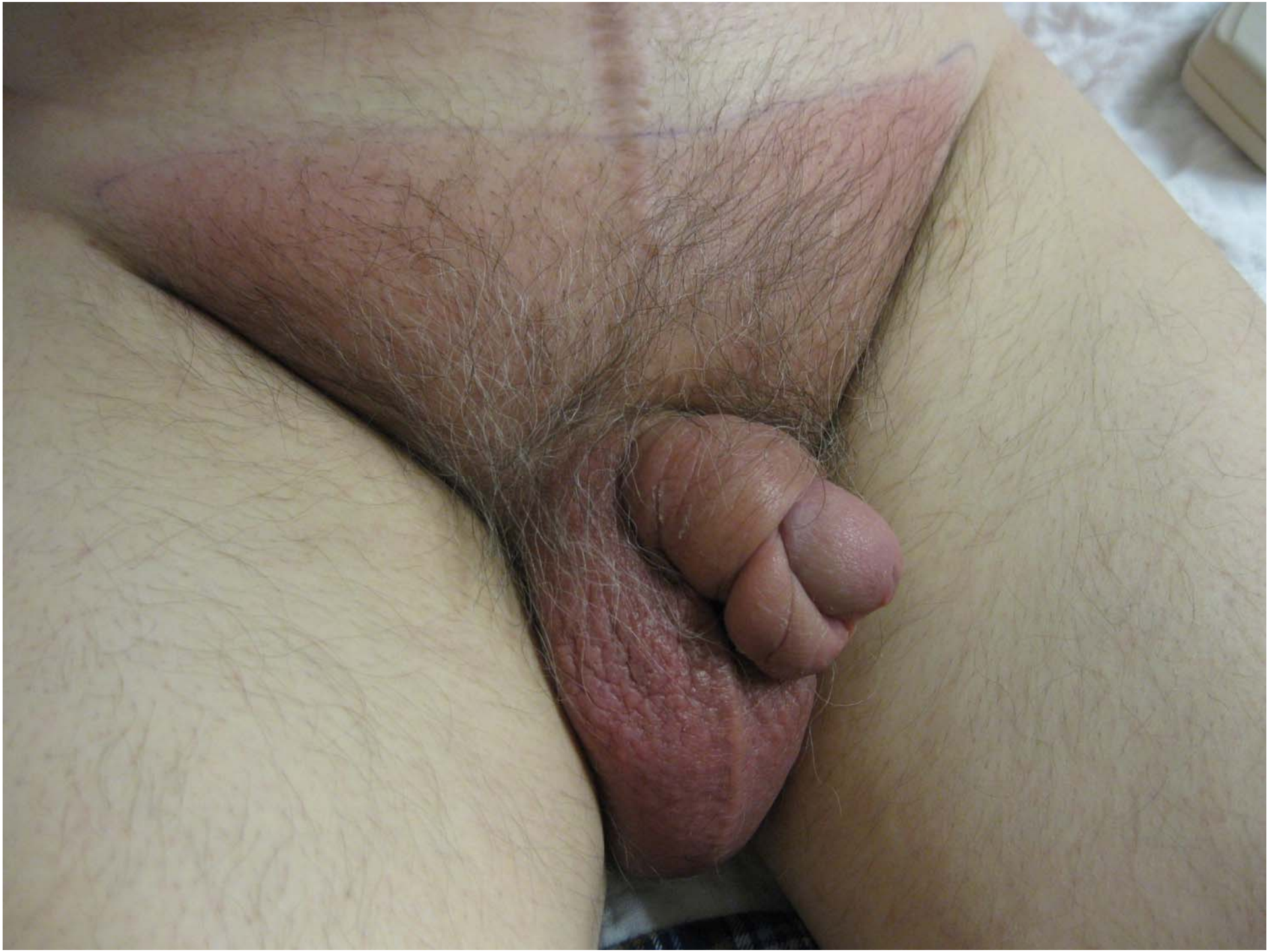
A. Psoriasis

Topical steroids

What preparation of topical steroid provides the highest penetration?

A. Cream
B. Lotion
C. Gel
D. Ointment

D. Ointment



What is your diagnosis:

A. Exogenous
B. Cellulitis
C. Syphilis
D. Cutaneous Crohn's
E. Urinary tract infection

D. Cutaneous Crohn’s

Penile/Scrotal Edema

Crohn's disease presenting as prepuce and scrotal edema

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Metastatic cutaneous Crohn's disease, in which noncaseating granuloma infiltration of the skin occurs at sites separated from the gastrointestinal tract by normal tissue, is the least common dermatologic manifestation of Crohn's disease. We report a case of a 34-year-old man with metastatic Crohn's disease presenting as prepuce and scrotal edema with typical histopathologic features. We think that any unusual cutaneous lesion in patients with Crohn's disease should be biopsied. (J Am Acad Dermatol 2003;49:S182-3.)

CASE REPORT

In March of 1999, a 34-year-old man presented to our service because of painless, prepuce edema of 4 month's duration. His medical history was relevant for perianal fissure and fistule 3 years earlier. In April of 1997 he had presented with fever, weight loss, abdominal pain, and diarrhea with blood. Colonoscopic examination revealed normal-appearing rectal mucosa, and aphtoid ulcerations and scanty erythematous mucosal macules in the descending and sigmoid colon. A biopsy specimen showed single epithelioid granulomata. On the basis of these clinical and histologic features, a diagnosis of Crohn's disease had been made. He responded rapidly to treatment with prednisone (70 mg) and sulfasalazine (1500 mg daily).

When our patient presented in our department, he had no gastrointestinal symptoms and was receiving maintenance treatment with sulfasalazine (1000 mg daily). Physical examination revealed a homogeneous, slightly infiltrated, disfiguring edema of the prepuce and the foreskin of the penis, with mild involvement of the scrotum (Fig 1). No ulcers or any other cutaneous lesions were found. The glans was not affected. There was no associated lymphadenopathy and no history of trauma. There was not any obvious extension from known intestinal lesions.

Histopathologic examination showed a normal epidermis overlying a dermis that contained medium-sized, noncaseating epithelioid granulomas composed of numerous epithelioid cells, lymphocytes, and Langhans giant cells (Fig 2). Periodic acid–Schiff, acid-fast, and Ziehl-Neelsen stains were negative for fungal and mycobacterial elements. No foreign bodies were found by polarizing microscopy.

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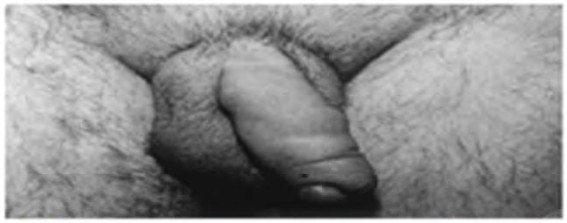


Fig 1. Disfiguring edema of prepuce and foreskin of penis, with mild involvement of scrotum.

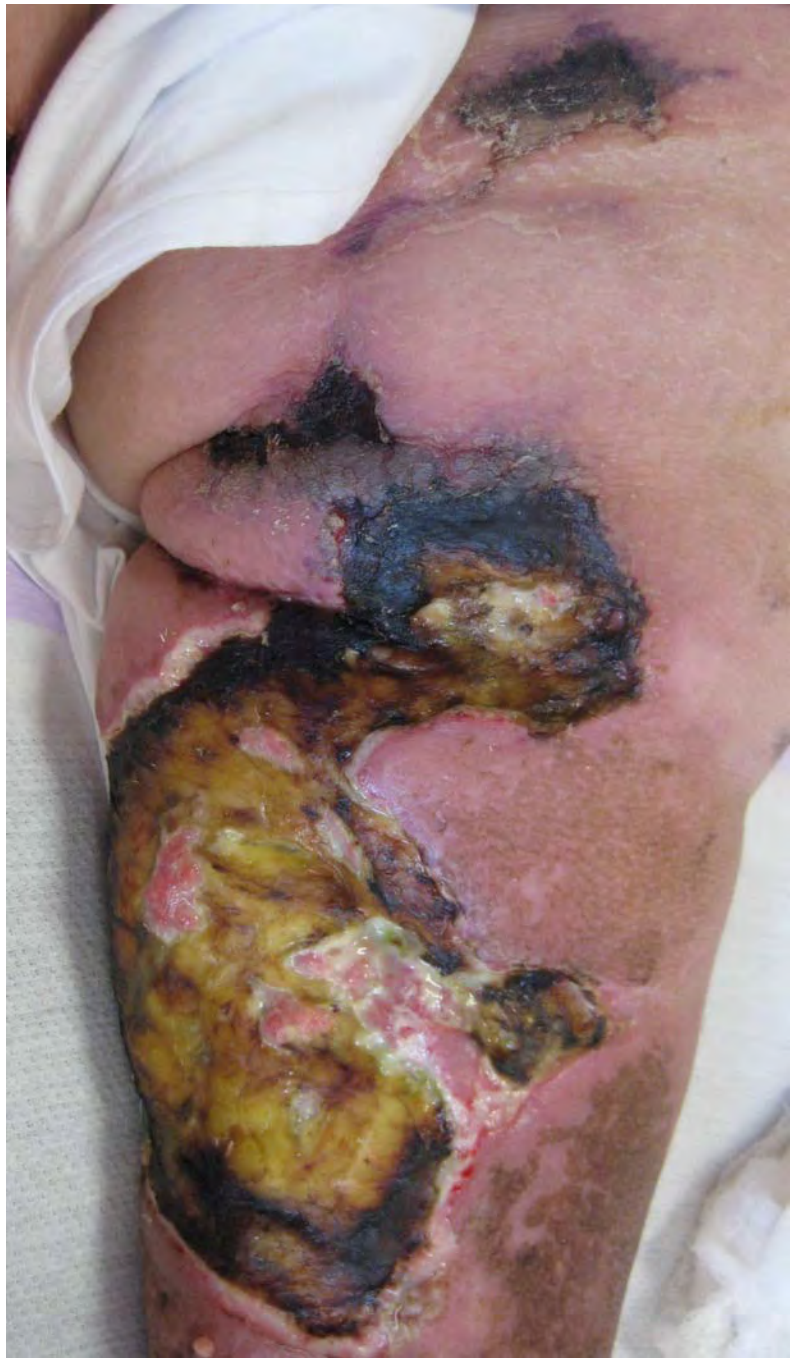
Laboratory investigations, including basic hematologic and biochemical examinations, produced normal results, as did radiograph of the chest. A Mantoux test produced negative findings.

A diagnosis of Crohn's disease involving the genitalia was made.

Our patient began therapy with metronidazole (1000 mg) and sulfasalazine (2000 mg) daily. Three weeks later there was no clinical response, so we began oral prednisone at 1 mg/kg per day. Within 2 weeks, the edema progressively improved. The dose of prednisone was gradually tapered, but at 0.5 mg/kg per day, relapse of the edema occurred. Then we added cyclosporine treatment at 5 mg/kg per day. The edema disappeared almost completely in 2 months. Finally, we added azathioprine 2 mg/kg per day and complete resolution of the edema was achieved in 3 months. Prednisone, cyclosporine, and azathioprine were gradually withdrawn. After 6 months of follow-up, there was no recurrence of the edema.

DISCUSSION

Crohn's disease is a chronic, relapsing disease that may affect any part of the alimentary tract from the mouth to the anus. There are numerous extraintestinal features, including lesions of the skin. These may occur in 10% to 44% of patients.[1-3] There is



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What can be associated with this condition?

A. Secondary hyperparathyroidism
B. Hepatic failure
C. Diabetes
D. Warfarin use
E. All of the above

All of the above

Thank you!

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