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A skin diagnostic dilemma in a young female

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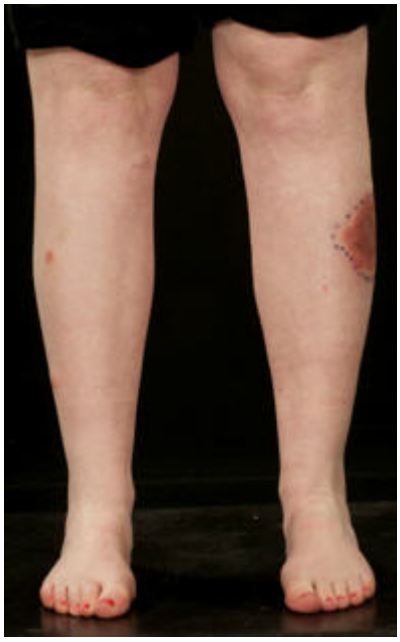
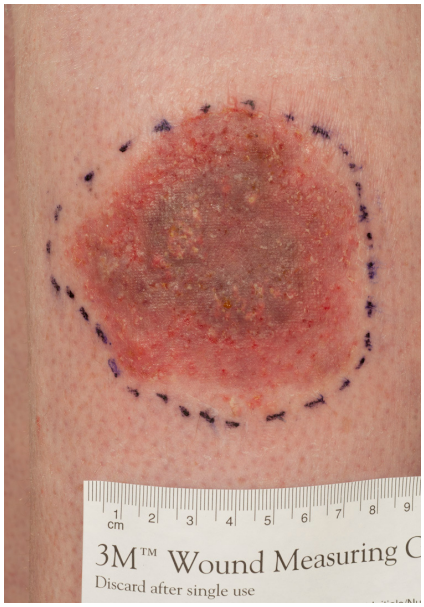
Clinical—A 30-year-old lady presented with a lesion on her left lower leg, present for 3 months, which started as a small erythematous area. She thought it was an infection at the site of a spider bite.

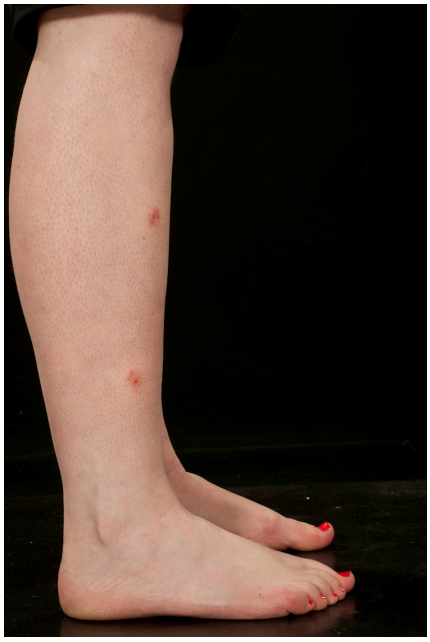
She was seen by multiple doctors and had multiple courses of antibiotics with little effect. The lesion grew and became raised and vesiculated. She had recently noticed two new lesions on the right leg.

Left leg lesion





Right leg lesions



What is the diagnosis?

Answer—She was reviewed by the dermatologist who recognised it as *discoid eczema*. She used clobetasol propionate 0.05% cream, a potent topical corticosteroid, and it improved dramatically. We also continued antibiotics for super-infection for 2 weeks.

Discussion—Discoid (or nummular) eczema is a common (prevalence 0.1–9.1%)[1] type of dermatitis affecting any part of the body especially the lower legs. Insect bites or skin injury can precipitate it. It is slightly commoner in adult males. Some cases are associated with atopy or venous stasis.

The lesions are well-defined, round or oval, often vesiculated in the acute stage, and subsequently become dry and erythematous. Pruritus is not always present. However it may present without an acute phase, particularly in the elderly, when dry skin is a causative factor. Acutely it can be mistaken for impetigo, while in the chronic phase it is often confused with psoriasis or fungal infection.

Treatment is with potent topical steroids and topical or oral antibiotics for secondary infection. In addition it is important to use soap substitutes such as emulsifying ointment and emollients regularly. These should be continued after the eczema has resolved to help prevent recurrence.

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Reference:

1. Marks R. Eczema. London: Martin Dunitz; 1992.