# DERM DILEMMA

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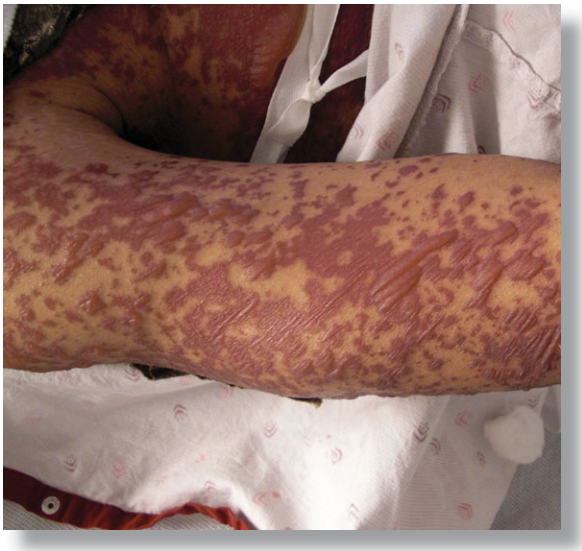
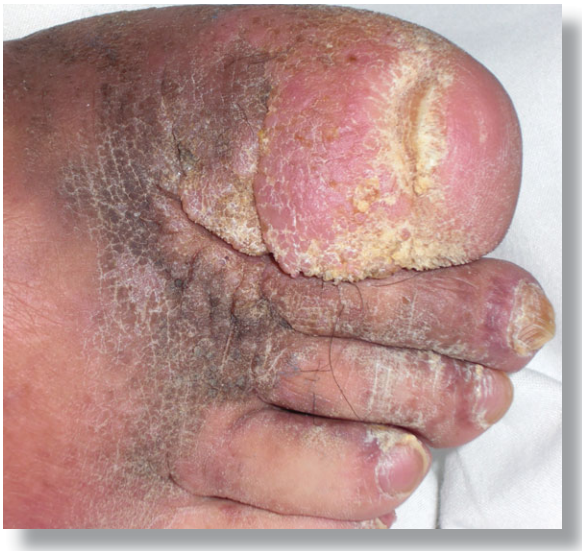
## CASE 1



A 59-year-old man presents with fever and a severe, painful, erythematous, blistering rash of 2 days' duration. You learn that he was started on lamotrigine for a seizure disorder approximately 3 weeks before the rash first appeared. Beginning with erythema and bullae on the trunk, it spread to the neck, face, and proximal extremities. The patient also developed erythema and erosions of the buccal, ocular, and genital mucosae. By now the condition has progressed to skin detachment over more than 30% of the patient's body surface, and your consulting dermatologist notes a positive Nikolsky sign (firm fingertip pressure on the skin produces a blister).

**What is your diagnosis?**

## CASE 2

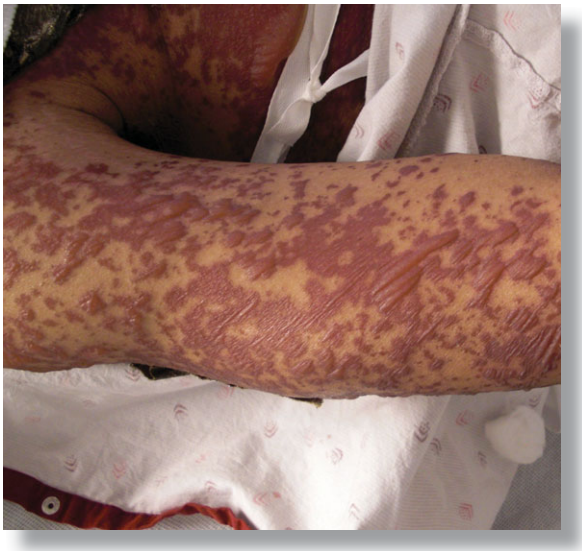


Troubled by chronic progressive swelling of the legs and feet associated with thickening of the skin, a 68-year-old man comes to your clinic for help. He tells you this has been a problem for several years. Examining him, you note that his toes, feet, pretibial surfaces, and calves do appear swollen. The skin demonstrates brownish hyperkeratosis, fibrosis, and some verrucous changes overlying the toes, dorsal feet, and pretibial surfaces. He has a long history of obesity as well as congestive heart failure that has been poorly controlled.

**What is your diagnosis?**

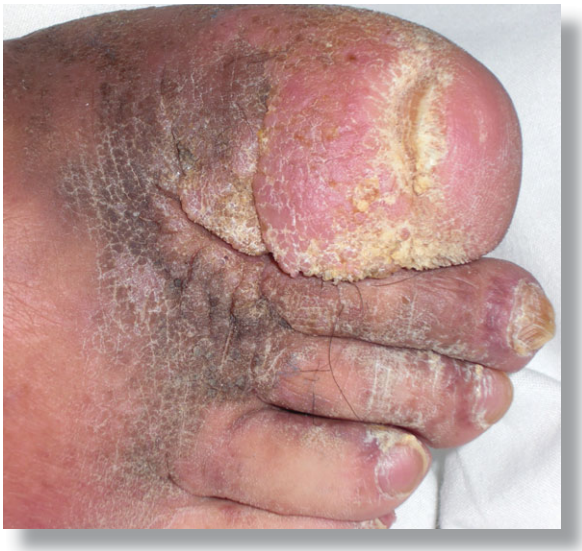
*Turn page for answers*

## CASE 1



The correct diagnosis in this case is toxic epidermal necrolysis (TEN)—an acute and life-threatening mucocutaneous hypersensitivity reaction that is almost always medication-related. Most frequently implicated medications include nonsteroidal anti-inflammatory drugs, antibiotics (especially trimethoprim-sulfamethoxazole), and the antiseizure drugs (especially lamotrigine). Patients develop extensive keratinocyte cell death and significant areas of skin separation at the dermal-epidermal junction. The latter is diagnostic for TEN when it exceeds 30% of the total skin surface. Mortality averages 25% to 35%. If possible, these patients should be admitted to a burn unit for management.

## CASE 2



This patient is suffering from elephantiasis nostra verrucosa, which can be secondary to a combination of lymphedema and venous insufficiency. It is especially common in long-standing chronic lymphedema. The skin becomes hyperkeratotic, discolored, and fibrotic and may develop verrucous lesions. A referral to a lymphedema specialist is helpful to confirm the etiology and provide assistance in management.

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