

CLINICAL IMAGES

Dyshidrotic eczema following intravenous immunoglobulin treatment

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A 57-year-old man with chronic inflammatory demyelinating polyneuropathy had a pruritic rash on his palms 2 days following his first treatment with intravenous immunoglobulin. He had no known drug allergies or history of rashes caused by drugs. He was not aware of contact with new substances, and, aside from the intravenous immunoglobulin, he had not received any new medications. A complete blood count and metabolic panel were unremarkable. Full-body skin examination showed 1- to 2-mm vesicles distributed bilaterally on his palms and fingers (Figure 1) and was otherwise normal. Our differential diagnosis included dyshidrosis, palmoplantar pustulosis and pustular psoriasis. Histopathologic examination showed acanthosis with marked spongiosis and intraepidermal vesicle formation, suggestive of dyshidrosis. We prescribed localized treatment with triamcinolone 0.1% ointment. On follow-up 2.5 weeks later, the pruritus was markedly improved and the vesicles had resolved, leaving superficial nontender skin desquamation (Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.121036/-/DC1) consistent with resolving dyshidrosis. At 6-weeks follow-up, all lesions had resolved. Our patient has not received further treatment with intravenous immunoglobulin.

Dyshidrosis, also known as vesiculobullous hand eczema or pompholyx, is a type of dermatitis characterized by pruritic, tense, deep-seated vesicles that are acute, chronic or recurrent, and appear suddenly on palmoplantar surfaces. It has been associated with contact allergens, fungal infections, generalized eczema and intravenous immunoglobulin infusion.¹⁻³ When associated with intravenous immunoglobulin, symptoms typically occur within a few days of the infusion. On rechallenge with intravenous immunoglobulin, dyshidrosis can reoccur.¹⁻³ Dyshidrosis is



Figure 1: Scattered 1- to 2-mm deep-seated vesicles on the palm of a 57-year-old man following treatment with intravenous immunoglobulin.

typically treated with mid- to high-potency topical corticosteroids, along with frequent use of moisturizer.^{1,2,4} Oral antihistamines may also be warranted for symptomatic relief of pruritus.²

References

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