When the Rash Doesn't Fit: An Atypical Presentation of Dermatitis Herpetiformis

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Introduction

Dermatitis herpetiformis (DH) is a chronic autoimmune condition causing a pruritic rash. Prevalence ranges from 1 per million to 75 per 100,000, depending on geography.[1] It is most common in Northern European populations and is typically associated with gluten sensitivity enteropathy, also known as celiac disease.[2] The rash typically presents on extensor surfaces, buttocks, or neck. [3] We present a case of a 30-year-old female with atypical distribution of DH.

Case Information

Description of Patient and Present Illness

A 30-year-old female with a past medical history of acne, and dermatillomania presented with a rash on the chest and back. She reported that it has been going on for a year and worsens with showers. Failed therapies include topical steroids, antifungals, doxycycline, benzoyl peroxide wash, sulfur washes, and clindamycin lotion.

Physical Exam Results

Inflamed red papules that were edematous with overlying excoriation and heme crust on the chest and back. Previous biopsy was consistent with pityrosporum folliculitis, but on secondary biopsy, results indicated fine granular deposits of IgA along the epidermal and follicular basement membrane zone consistent with dermatitis herpetiformis.

Images



Figure 1: Clinical Photo depicting atypical distribution of papules on the patients back

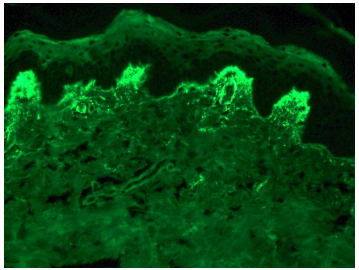


Figure 2: An example of DIF showing granular IgA deposits in the dermal papillae

Implications/Discussion

Atypical presentations of dermatitis herpetiformis depart from the classic picture of intensely pruritic, symmetric papulovesicles over the extensor elbows, knees, buttocks/sacrum, and scalp. The most consistently reported atypical forms are acral/palmoplantar purpura, purely localized disease, unusual anatomic sites, seronegative/enteropathy-negative disease, and mucosal or nonvesicular morphologies.

Conclusion

We report an interesting case of DH on the back. This case emphasizes the need to maintain DH in the differential diagnosis, even in patients with atypical clinical features. Recognition and broader diagnostic evaluation could have alleviated this patient's prolonged symptoms through avoidance of triggers and initiation of dapsone.

References

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