

Atypical Erythema Multiforme? A Case Report

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Background

- Erythema multiforme is a hypersensitivity skin condition that consists of a characteristic “target” like lesion with macules and papules.
- It is typically acute and self-limiting, is symmetrical with a preference for the distal extremities and associated with certain infections or medications. The most common etiology is herpes simplex but many other organisms, such as mycoplasma pneumoniae and HIV, have also been implicated.

Case Presentation

- A 63-year-old man presented with a diffuse, maculopapular, blanching, erythematous rash of unknown etiology with mild pruritus that began 6 days prior on his knees and thighs bilaterally, eventually spreading to his legs, arms, trunk, and neck. He was afebrile and denied numbness, tingling, joint pain. He experienced the same rash several years ago and it resolved without treatment; skin biopsy at the time was unrevealing.
- The patient’s history includes HIV treated with ART, insulin-dependent diabetes mellitus, hypothyroidism, and a 2018 episode of Stevens-Johnson syndrome from antibiotics (possibly cefepime).
- Physical examination revealed flaking of the superficial skin layers, but no tenderness or mucosal involvement. Skin biopsy showed linear fibrinogen at the dermal-epidermal junction, suggesting interface dermatitis or lichenoid drug eruption, but remained inconclusive.
- Initial treatment included corticosteroids, Benadryl, and insulin. The patient’s ART medications, HCTZ, L-arginine, and fenofibrate were held to assess if they caused the rash.
- The following week, the rash expanded on the back and evolved over all affected areas. It changed in color from light red to darker red-brown to light red again with bright red borders. The patient was discharged on prednisone 20mg BID. Following discharge, the rash continued to improve over the following weeks.

Conclusion

- This case illustrates the complexity of diagnosing rashes for which there is an unclear etiology, atypical presentation, and inconclusive testing. This may serve as an example of the potential outcomes in patients with multiple comorbidities and polypharmacy.

Figure 1. Right upper extremity – upper arm



Figure 2. Right upper extremity – hand/wrist



Figure 3. Left lower extremity – upper leg/knee



Figure 4. Left lower extremity – ankle/foot



Figure 5. Anterior neck and chest



Figure 6. Upper back



References

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