

A common cause of photodistributed rash

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A 57-year-old woman is referred to the dermatology clinic by her primary care provider for evaluation of an itchy rash that has been present on her chest, upper back, and the lower halves of her arms for the past 2 months. The rash, which frightened the patient, had persisted despite several short courses of prednisone and the application of several tubes of topical corticosteroid cream (triamcinolone 0.1%).

The patient denied being allergy prone and denied the use of any new products on her skin, but she still believed she had contact dermatitis. Aside from being overweight, the patient's only other health problem was recently diagnosed hypertension. She had started taking hydrochlorothiazide a month before the rash started, and although she had ceased taking the drug, the rash persisted.

On examination, a solid pink, blanchable rash was visible on the patient's neck, chest, and upper back, but especially on the arms (see Figure 1). Below her neckline, front and back, and above her sleeves, the skin appeared normal, with sharply demarcated lines separating involved from uninvolved skin. No epidermal disturbance, such as scaling or blistering, was appreciated. The face and hands were spared. Given the facts as presented, which of the following is the most likely explanation for this patient's rash?

- Contact dermatitis
- Dermatomyositis
- A phototoxic reaction to hydrochlorothiazide
- Lupus

Discussion

The correct answer is a phototoxic reaction to hydrochlorothiazide, which is a very common reaction pattern that can persist for weeks following cessation of the drug. Dermatomyositis can manifest as a sunburn-like rash as well but will not demonstrate such sharply defined margins, nearly always involves the face, and will usually be seen on a patient who is also weak and often in pain. Contact dermatitis was a definite possibility for this patient, but at some point the rash would

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FIGURE 1

A persistent, itchy rash



have demonstrated a less symmetrical distribution along with papulovesicular and/or scaly changes to the epidermis instead of the fixed, sunburn-like rash seen on this patient. Lupus should always be considered when a photodistributed rash is seen, but lupus will likely demonstrate focal epidermal changes including scaling, follicular accentuation, and, eventually, annular lesions with central atrophy.

Treatment Photodistributed rashes represent a significant category in dermatology, typifying the maxim that the clinician should take note not only of where a rash is but also of where it is not—in this case, where the sun seldom shines. The sharply defined borders on the patient's arms were suggestive as well, although this pattern is often seen in cases of contact dermatitis too. A rash caused by a phototoxic reaction to hydrochlorothiazide can take weeks to clear, even after cessation of the drug. Topical corticosteroid creams and hydroxyzine pamoate, 50 mg at bedtime, helped this patient to get through the recovery period. □