DESCRIPTION
A 31-year-old man presented to dermatology with a 4 day history of an intensely itchy, linear, vesicular rash affecting the palms of both hands, on the background of recent exposure to a patient with scabies. The patient had a history of childhood eczema and asthma but no exacerbations in adulthood. Examination and microscopy revealed a vesicular rash with an absence of any burrows, mites or eggs. A provisional diagnosis of pompholyx eczema was made and the patient was commenced on mild topical corticosteroids. The patient re-presented 5 days later with worsening symptoms and a severe vesico-bullous rash (figure 1) and was commenced on oral prednisolone and high strength topical corticosteroids. Symptoms initially continued to progress for 2 further days with enlarging of the bullae (figure 2). The image demonstrates the coalescence of vesicles to form tense bullae adjacent to areas of multiple vesicles (figure 3). Following a 1 month tapering

Figure 1  Rash on palm of left hand demonstrating multiple bullae and vesicles.

Figure 2  Further progression of bullous lesions.

Figure 3  Large bullae adjacent to multiple small vesicles.
dose of steroids the patient remained symptom free at initial follow-up (figure 4). Pompholyx eczema is a common condition causing pruritic vesicles and bullae on the palms of the hand and soles of the feet. Differential diagnoses include pustular psoriasis, bullous pemphigoid and contact dermatitis. The exact causal mechanism is unknown although contact dermatitis and concurrent mycoses have been implicated in the pathogenesis of some cases. Topical and systemic corticosteroids are the mainstay of treatment but there are reports of cases that have been treated with botulinum toxin and calcineurin inhibitors.

Competing interests None.
Patient consent Obtained.

REFERENCES

Figure 4  Complete resolution after 1 month of oral and topical steroid treatment.