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A 25-year-old healthy man was admitted with a 3-month history of joint pains in his feet and right knee, leading to difficulty ambulating. The patient had been previously treated without a definitive diagnosis, with NSAIDs and systemic steroids, without improvement. He also endorsed a 3-week history of an extensive, diffuse rash with significant involvement of the palms, soles, and genitals. He denied involvement in the oral mucosa or conjunctiva. Lesions were tender—the plantar lesions contributing significantly to painful ambulation. The physical examination was notable for hyperkeratotic scaly purpuric papules and plaques on the soles and between the toes, hyperkeratotic ostraceous nodules on the arms, knees, trunk, and soles, and erythematous scaly plaque on the groin involving the penis. Right fourth finger PIP with swelling. Oral mucosa and conjunctiva were clear; nails were normal. Labs were notable for leukocytosis and elevated inflammatory markers; the urine was positive for chlamydia trachomatis, negative for gonorrhea and HIV, syphilis, ANA, RF was negative while HLA-B27 positive. The diagnosis of reactive arthritis was made and treatment with indomethacin, doxycycline, and prednisone resulted in mild improvement during his hospitalization. This case represents the classic presentation of reactive arthritis with keratoderma blenorrhagicum and balanitis circinata with chlamydia trachomatis infection. Keratoderma blenorrhagicum is characteristic of reactive arthritis, although occurring in only 10% of patients. In patients with palmoplantar keratoderma or otherwise typically appearing psoriasis and psoriatic arthritis, it is important to consider the diagnosis of reactive arthritis and expand the history and physical to elucidate the diagnosis.

Commercial Disclosure: None identified.

34361

Laser hair removal treatment considerations for Ehlers Danlos syndrome

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EDS is a clinically and genetically heterogenous group of heritable connective tissue disorders involving a pathogenic disruption of collagen fibrils. Here we present a case of laser hair removal in the setting of EDS (type 6a) in a 29-year-old female phototype 2 patient successfully treated with 755-nm alexandrite laser for aesthetic laser hair removal. Our patient was born with a dislocated hip and diagnosed at age 6 with EDS type 6a with genetic confirmation of PLOD1 positive gene mutation, poor wound healing, chronic sacroiliac joint dysfunction, kyphoscoliosis and bilateral hip dysplasia. She also had a myocardial infarction, right renal artery dissection and iliac artery dissection. She was interested in aesthetic laser hair removal and noted a significant scarring history with numerous hypopigmented scars throughout her extremities with shaving leaving her with scarring on occasion. Given her complex connective tissue disease history with significant morbidity particular consideration was given to planning her laser hair removal treatment sessions for the bikini line. Clinically our patient was phototype 2 with the bikini line containing dark brown terminal hair. To clinically identify endpoints and mitigate potential complications including scarring a test spot was initially performed. The test spot was performed with the alexandrite laser 755 nm, fluence 16 J/cm^2, 10-ms pulse duration, 18-mm spot size, dynamic cooling device with 4 total pulses in separate areas. No undesirable endpoints, pigmentary alteration, or scarring was observed and full treatment sessions were initiated with 755-nm 16-18 J/cm^2, 10-ms pulse duration, 18-mm spot size, dynamic cooling device with excellent clinical response.

Commercial Disclosure: None identified.

34767

Kombucha-induced irritant contact dermatitis

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A 30-year-old woman presented with a 2-month history of an intermittent rash on the bilateral upper cutaneous lip. Rash was originally thought to be early herpes simplex, but was unresponsive to a 7-day course of valacyclovir. Patient noted the rash to appear during periods of increased consumption of kombucha, a fermented tea. She had only been applying petrolatum to the area. She had no history of atopy, and no significant medical history. She worked in a hospital without any significant occupational exposures. On the upper cutaneous lip there were 2 symmetrically placed pink macules. The presumed diagnosis was an irritant contact allergy in response to the increased consumption of kombucha. The patient was advised to decrease consumption of kombucha, with resolution of the rash occurring within 1 week. Kombucha is a slightly sweet and acidic beverage made of fermented black tea and a symbiotic culture of yeasts and bacteria. Believed to first have originated in China, it has recently gained popularity due to its potential health benefits; however, there remain a paucity of benefits reported in literature. To our knowledge, this is the first report of a kombucha-induced irritant contact dermatitis, which is likely due to the high pH (approximately 2.8) of the fermented tea. This case highlights the importance of a thorough history in patients with suspected contact dermatitis with emphasis on both topical products as well as herbal remedies.

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33887

Lenalidomide-induced pityriasiform eruption followed by blaschkitis in a patient with multiple myeloma

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Lenalidomide is a thalidomide analog used in the treatment of hematologic malignancies such as multiple myeloma (MM). We present a previously undescribed pityriasiform eruption due to lenalidomide followed by a secondary eruption suggestive of blaschkitis. A 76-year-old Chinese man with MM presented to the dermatology clinic with a progressive, pruritic eruption on the chest and axillae bilaterally for 1 year. The eruption emerged 2 weeks after receiving lenalidomide following an autologous stem cell transplantation for MM. On examination, the patient had erythematous, hyperpigmented scaly papules and plaques on the lateral chest and axillae bilaterally. A skin biopsy demonstrated lichenoid and perivascular lymphocytic infiltrate with scattered eosinophils, neutrophils, and extravasated erythrocytes, consistent with a pityriasiform eruption. The patient discontinued lenalidomide and started a topical over-the-counter corticosteroid for 2 weeks. The patient noted marked improvement in the eruption and associated pruritus. After a drug holiday of 2 months, the patient resumed lenalidomide. Five days later, a pruritic eruption appeared involving the bilateral axillae and left lower abdomen circling around to the left lower back. On examination, erythematous macules and papules were noted to coalesce over a salmon-colored base along the lines of Blaschko, extending from the left lower abdominal quadrant, crossing the left flank and continuing to the left lower back without crossing the midline. The patient was recommended to treat through this eruption and was instructed to apply a topical corticosteroid cream and resume lenalidomide. A month later, the patient reported that the eruption and associated pruritus resolved with the aforementioned.

Commercial Disclosure: NA