Was it the Butcher?

Have I Got a Case for You! SD State ACP Meeting
By Dr. Randall Lamfers
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Chief complaint

50 yo Caucasian male presenting with numerous skin lesions of various stages.

When I encounter dermatology cases I always like to do the following:

1. Ask to see the lesions before I start asking questions

2. If lesions are at various stages try to find one that is at the early stage
Left hand
Left leg
History of Present Illness:

About 1.5 weeks ago he had a superficial injury to his left hand while using a screwdriver to clean meat off a door at a butcher shop in SD.

Started to develop erythema around the site, pustule developed, drained, then became ulcerated. A few days later he noticed blisters and pustules over the extremities, trunk, and face.

He was in Arizona when this worsened. Went to urgent care started on clindamycin. Over last 2 days no improvement. Presented to our ER.
• What is your Differential Diagnosis?
History continued

PMHX: HTN, Depression

ALL: NKDA

MEDS: Clindamycin

FMHX: No hx of malignancy, no autoimmune disorders, no skin disorders

SCHX: Single, sexually active - does not use protection, occupation - truck driver, some alcohol use, no tobacco use.

ROS: + chills, + sweating, no visual complaints, no arthralgia or myalgia. Recent sore throat but has resolved.
Physical Exam

Vitals: T 99.8, BP 139/89, HR 100, RR 16, O2 sat 97% on RA

Exam:

Pertinent positive was the skin findings

Pertinent negatives were - no mucosal involvement, no adenopathy, no hepatosplenomegaly, no evidence of synovitis
Labs:

CBC: WBC 18.6 with 83%N, E 1.3%, no bands, Note hgb and plts are normal.

BMP: na 136, K 4.2, cr 0.78
• What is your DDx and what is your plan of care?
DDX:

1. Infectious Etiologies
   a. Cutaneous anthrax
   b. Tularemia
   c. Brucellosis
   d. Fungal - blastomycoses, histoplasmosis, sporotrichosis
   e. Viral

2. Bullous pyoderma gangernosum

3. Sweet syndrome

4. Vasculitis
Plan of care:

Started the patient on Ciprofloxacin and Clindamcyin

Obtained the following other tests:

1. HIV antibody negative
2. Tularemia titer <1:20
3. Fungal serology (aspergillus, blasto, histo, coccido) negative
4. Spotted fever antibody <1:64
5. B. Anthracis PCR - negative

Consulted Dermatology for Biopsy

Note that skin lesions were worsening
Pathology

Punch biopsy of a lesion on left thigh:

Spongiotic epidermis with infiltrating neutrophils and extensive edema with subepidermal vesiculation. Dermis shows extensive superficial and mid dermal neutrophilic infiltration with rare eosinophils. No fungal elements.

Impression: Extensive neutrophilic dermatosis most consistent with Sweet syndrome.
Sweet Syndrome

• Diagnostic criteria: need both major and 3 minor
  A. Major
    1. Abrupt onset of skin lesions
    2. Pathology consistent with Sweet’s syndrome
  B. Minor
    1. Preceded by associated systemic findings
    2. Fever and constitutional signs and symptoms
    3. Excellent response to steroids
    4. Lab abnormalities
      a. Elevated wbc count with greater than 70% neutrophils
      b. Elevated ESR or CRP

Causes of Sweet Syndrome

1. **Idiopathic** is most common 50%

2. **Malignancies** 35% - in particular hematologic malignancies

3. **Drugs** - Granulocyte stimulating factors most common. A couple commonly used drugs - nitrofurantoin, trimethoprim-sulfamethoxazole, furosemide.

4. **Infectious** (URI/GI)

5. **Inflammatory autoimmune disorders** such as IBD and connective tissue disorders

6. **Pregnancy**
Treatment of Sweet Syndrome

First Line Therapy

1. Prednisone is the treatment of choice
2. Colchicine 0.5 mg 3x a day
3. Potassium iodide 300 mg 3x a day

Other things to look for:

- Superimposed bacterial infection with staph aureus
- Treat underlying systemic process if present

Cohen P - AM J Clinics Dermatology 2009
References

