1/25/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Siva (@)* ***Case Discussants****: Anmol (@) & Rahul (@)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Manaswini)

CC: 70y/o M with **chronic rash on left leg**

HPI: Rash present for many years, tends to worsen during summer, [improves during the winter], affects the back of his left leg. Over past 2 weeks, worsened and become very **pruritic**. He admits to frequent scratching.

Tried a zinc oxide and hydrocortisone to the area without resolution. Used alcohol on the rash too.

ROS (+): Chronic diarrhea with fecal incontinence, Increased sweating in L lower leg [↑ at night].
No fever, chills, weight loss, join pain, weakness or numbness around the rash

PMH: **Rectal adenocarcinoma** (s/p XRT and reversal of ileostomy, c/b anastomotic leak req R hemicolectomy –prolonged hospitalisation
HTN, DISH

Meds: Vit B12, Lisinopril, lidocaine, loperamide, dicyclomine, multiple vitamins

Fam Hx:
lung cancer [father]

Social Hx:
No recent travel, no new topical products, no known exposures

Health-Related Behaviors: Non smoker, No use of alcohol

Allergies: -

Vitals: Stable Vitals
Exam: Normal CVS, Pulmonary, Abdominal, CNS exam

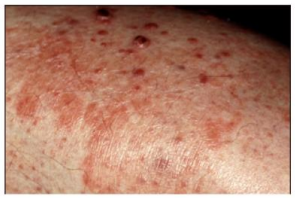
Skin exam: Large confluented well-demarcated **hyperpigmented plaque w/ overlying scale** on L posterior leg involving buttocks, with erythematous follicular papules and erythematous **raised border** at inferior aspect
All ten toenails with onychodystrophy and onycholysis, some erythematous scale on bilateral heels

Notable Labs & Imaging:
Hematology:
WBC: 4.5 [with nl diff] **Hgb**: 10.4 Plt: 190 MCV: 95.2

Chemistry: Na, K, Cl: nl
AST, ALT, Alk-P, Bili: nl Albumin: 3.4

CMP, LFT, RFT - wnl

KOH prep- Positive for Branching septate Hyphae



Dx: **Tinea Corporis exacerbated by moisture & immobility, with follicular involvement -Majocchi's Granuloma**

Problem Representation: Elderly immunocompromised man with chronic hyperpigmented scaly erythematous folliculocentric-papular pruritic rash with raised borders at an Intertriginous area with branching septate hyphae on KOH mount

Teaching Points (Eyron)

Approach to Rash
Acute - think SJS vs. TEN
Chronic Rash - why present now?

-Chronic diarrhea can be a risk factor for vitamin deficiency leading to rash

-Skin scratching → irritation → keratinization → hyperpigmentation

-Fungal infection can lead to subsequent bacterial infection

Skin with No Alarm Features:
Irritants, Infections, Drugs, Dermatitis, Psoriasis

- **Intertriginous physiology (skin barrier breakdown): prone to infections -Dermatophytes/candida/bacterial**
- **Steroids and alcohol worsen fungal infections.**
- **Follicular component could be suggestive of Majocchi's granuloma 2/2 chronic fungal infection .**
- **Tinea corporis → superficial (stratum corneum)**

- ***Majocchi's granuloma*** **→ follicular + dermal invasion-topicals don't penetrate deep enough ,so systemic therapy is needed.**