

# Dermatology Digest

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**FIGURE 1**  
A widespread  
periorbital rash

## Too much attention makes this problem worse

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### ›CASE

The patient is a 33-year-old woman who was referred to the dermatology clinic for evaluation of a rash on the periorbital skin of both eyes that had been present off and on for months. The patient reported that the rash had persisted even though she had applied numerous products—including petroleum jelly, baby oil, facial moisturizer, OTC 1% hydrocortisone cream, clotrimazole cream, and triple antibiotic ointment—to try to clear it. The patient's primary care provider had prescribed tacrolimus ointment (Protopic) and then had advised her to apply Tinactin (tolnaftate). The patient had also changed her brands of makeup several times and finally stopped using makeup altogether, all to no avail.

The rash had had no effect on the patient's vision, and she denied having used any new or old products, such as contact lens solution or eye medications, in or around her eyes. On further questioning, the patient revealed that she was highly atopic, with a history of asthma and eczema as a child. She had sensitive skin in general, but she had no rash elsewhere on her body. This periorbital rash had begun in the dead of winter.

On physical examination, the entire periorbital areas of both eyes were covered with an impressively red to orange scaly rash (see Figure 1). A KOH (potassium hydroxide) preparation test was performed, and results were negative. Examination elsewhere failed to show any evidence of other skin disease, such as psoriasis or seborrhea.

### ›GIVEN THE FACTS AS PRESENTED, THE LEAST LIKELY DIAGNOSIS IS

- *Atopic dermatitis*
- *Neurodermatitis*
- *Xerosis*
- *Contact dermatitis*

### ›DISCUSSION

The ONE clearly incorrect diagnosis, given the facts of the case as presented, is xerosis, or dry skin. This choice is wrong because the patient had already applied any number of moisturizers to the affected area to no good effect. The other conditions all belong in the differential diagnosis.

This case illustrates a complaint that is extremely common in middle-aged women. Most women who have this problem simply suffer from atopic dermatitis, which manifests as dry, sensitive skin that the person finds difficult to leave alone, as was true for the patient in this case. Typically, a sufferer applies many products to try to deal with the problem, and some of them may well make things worse. The scratching or rubbing, which is hard to stop, certainly exacerbates the problem worse as well. In this sense, the condition becomes a form of neurodermatitis: the skin becomes hypersensitive from all the attention it is receiving, which begets more attention, and so on. Like the scrotal skin in men, the skin around the eyes is quite thin and therefore easily damaged.

The irony is that even though dry skin almost certainly played a part in this patient's problem, it did not cause the problem—a point made abundantly clear by the lack of response to adequate moisturizer application. Other diseases such as psoriasis and seborrhea could have caused this patient's complaint, but there was no corroboratory history or finding on examination to support those diagnoses.

By definition, patients with atopic dermatitis have dry, sensitive skin that is easily disrupted and disturbed by any number of triggers. Even though makeup is seldom implicated in the condition, nail polish and other contactants are known to cause it. As in this patient's case, the excessive attention paid to the skin is the critical ingredient. This patient was able to clear her condition with 2.5% hydrocortisone

ointment, applied sparingly at bedtime only, and for no more than a few days in a row. A bit of patient education was also in order because this problem will likely resurface, often when the humidity falls in the winter. [JAAPA](#)