

Dermatology Digest

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FIGURE 1
Eruption on the chest
of an elderly man



A spreading, chronically itchy rash

Lisa Mainier is an intern with an interest in dermatology at University Hospitals, Richmond Heights, Ohio. She has indicated no relationships to disclose relating to the content of this article.

›CASE

A 72-year-old white male presented with an “itchy rash” that had begun on his chest 2 months ago and had now spread to his upper back. No lesions were noted on the extremities. There was no generalized erythema, warmth, or fluctuance of the surrounding skin. The rash and the itching had increased with the warmer weather. OTC cortisone creams had offered only minimal relief. The patient, who had mildly elevated BP, denied previous rashes, recent illnesses, drug or environmental allergies, new medications, or new exposures. No family members were affected. He had no exposure to pets. Numerous small, discrete, erythematous, nontender papules, some of which were crusted or excoriated, were seen on the upper chest and back (see Figure 1).

›THE DIAGNOSIS IS

- *Folliculitis*
- *Atopic dermatitis*
- *Transient acantholytic dermatosis*
- *Tinea corporis*

›DISCUSSION

The patient had transient acantholytic dermatosis, or Grover’s disease. Usually self-limited, the condition may persist intermittently for several months to years.

Grover’s disease is a focal acantholytic dermatosis with associations to Darier’s disease and Hailey-Hailey disease. The cause of Grover’s disease is not well-understood. Usually seen in older white males, Grover’s disease may be triggered by heat, fever, persistent sweating,¹ sunlight,² or chronic mechanical irritation, such as prolonged bed rest. Grover’s disease may be associated with chronic renal failure, leukemia, cancer, and chemotherapy, or it can be completely idiopathic. Intense pruritus often interferes with daily activities or rest.

Folliculitis lesions, which contain a central hair, may be pustular and demonstrate fluctuance. The lesions of

atopic dermatitis typically appear on flexural surfaces. Adults are more likely than younger patients to have diffuse facial lesions with an erythematous background. Tinea corporis manifests as annular plaques with advancing borders of scale, papules, or vesicles.

Diagnosis Grover’s disease can be diagnosed clinically and confirmed by punch biopsy. Histology demonstrates acantholytic changes in the epidermis very similar to those of pemphigus vulgaris.³ Focal areas of spongiosis or intercellular edema cause separation of cells. In the dermal layer, infiltration with lymphocytes and eosinophils is one of the features that distinguishes Grover’s disease. Direct immunofluorescence of Grover’s disease is usually negative.

Treatment Advise patients to avoid heat or prolonged bed rest, and begin topical high-potency corticosteroids and liberal use of moisturizers to relieve the pruritus. If topical treatment does not provide relief, systemic nonsedating antihistamines may be added. More persistent and intense pruritus may require corticosteroids in tapered doses, retinoids, or methotrexate. The last two modalities require monitoring for side effects. Relapse is common following oral corticosteroid therapy. Topical vitamin D analogs, such as calcipotriene, may be helpful in recalcitrant cases but may not take effect for several weeks. Phototherapy and psoralen with UVA light may offer some relief for severe, persistent cases.⁴ Relief of itching is key to preventing secondary infection from chronic scratching. **JAAPA**

Joe R. Monroe, PA-C, MPAS, department editor

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