A dry, brownish-red rash

For over a year, this fit young man had been troubled by this persistent and occasionally itchy, discoloured rash on the axillae and groins.

Initially he had blamed his deodorant, soaps, foam baths and washing powders, but changing and finally discontinuing these did not help. He moved on to emollients which he assiduously applied before buying a supply of 1 per cent hydrocortisone at the pharmacist; however, none of these approaches brought about any improvement.

In desperation he sought advice from his GP. The well-demarcated, dry, brownish-red rash was noted and the GP’s suspicions of erythrasma were confirmed when the area was exposed to Wood’s lamp in a darkened room and found to fluoresce a coral pink. Microscopy and culture also confirmed the diagnosis of erythrasma. He prescribed the topical antibacterial agent fusidic acid cream to be applied three or four times a day. At long last, the rash cleared.

Erythrasma is a relatively common, chronic, superficial skin infection that affects intertriginous areas of the skin such as the axillae, groins and skin folds, where moisture from sweating, particularly at times of heat and humidity, encourages more prolific growth of the causative organism Corynebacterium minutissimum, which is a normal inhabitant of the skin.

The flexural rash of erythrasma may sometimes resemble psoriasis; it is therefore important to perform a general examination of the patient in case there are any signs that could indicate that psoriasis might be the cause.

Other conditions that may resemble erythrasma are intertrigo, candidosis, irritant contact dermatitis, seborrhoic dermatitis and tinea.

Erythrasma may occur at any age but the incidence of the condition increases with age. Patients at increased risk include the obese, those with diabetes, the immunocompromised and where poor hygiene is observed.
As in this patient, brownish-red, wrinkled, macular patches occur. Itching is sometimes a problem, but otherwise it may be asymptomatic. The diagnosis may be confirmed by the coral pink fluorescence under the UV light of a Wood’s lamp, or by microscopy and culture of swab or skin scrapings.

Localised areas will normally respond well to the application of a topical antibacterial agent such as fusidic acid cream; clindamycin solution that may be preferably in soggy intertriginous areas. Alternatively, an antifungal agent such as miconazole may also be effective.

If the condition is more widespread or not responsive a systemic antibiotic is appropriate, with the drug of choice being erythromycin 250mg four times daily for two weeks; alternatives include tetracycline, clarithromycin and ciprofloxacin.

The outlook for those with erythrasma is normally excellent but should it become widespread, as might occasionally happen in the immunocompromised, there could be serious complications such as abscess formation or septicaemia, but fortunately such events are rare.

Although clearance of the rash is normally readily achieved, recurrence is always a possibility. Patients should therefore be advised to ensure good hygiene in the future, to keep the skin cool and dry, to wear absorbent clothing and to try to tackle any problem of obesity.

By Dr Jean Watkins, a general practitioner in Ringwood, Hampshire