Unilateral Livedoid Hyperpigmentation of the Lower Extremity

Dillon Clarey  
*University of Nebraska Medical Center*

Devor O'Connor  
*University of Nebraska Medical Center*

Ashley Wysong  
*University of Nebraska Medical Center*

Follow this and additional works at: https://digitalcommons.unmc.edu/gmerj

Part of the Higher Education Commons, and the Medicine and Health Sciences Commons

**Recommended Citation**  
https://digitalcommons.unmc.edu/gmerj/vol3/iss1/35

This Conference Proceeding is brought to you for free and open access by DigitalCommons@UNMC. It has been accepted for inclusion in Graduate Medical Education Research Journal by an authorized editor of DigitalCommons@UNMC. For more information, please contact digitalcommons@unmc.edu.
Unilateral Livedoid Hyperpigmentation of the Lower Extremity

Creative Commons License

This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 License.

This conference proceeding is available in Graduate Medical Education Research Journal:
https://digitalcommons.unmc.edu/gmerj/vol3/iss1/35
Unilateral Livedoid Hyperpigmentation of the Lower Extremity

Dillon Clary, Devor O'Connor, Ashley Wysong

1University of Nebraska Medical Center, College of Medicine, Department of Dermatology
2University of Nebraska Medical Center, College of Medicine

Mentor: Ashley Wysong
Program: Dermatology
Type: Case Report

Background: Erythema ab igne is a clinical diagnosis that comes with a broad differential diagnosis. Through history taking and ruling out other reticulate dermatoses enables for its diagnosis. It is most often seen in cases of prolonged exposure to heat (space heater, laptop usage, heating blankets).

Case: A 40-year-old female with past history of livedo reticularis, hypertension, type II diabetes, obesity, and traumatic brain injury presented to the emergency department with a 1-month history of left lower extremity rash, edema, and bullae. She denied any remote history of intravenous drug use or chronic heat exposure. Recent outpatient workup for livedo reticularis revealed no evidence of venous/arterial insufficiency or deep venous thrombosis.

Examination demonstrated net-like violaceous patches consistent with livedo reticularis, some non-blanchable, over the left lower extremity. Overlying, there were several tense bullae with clear fluid and other deroofed bullae as well as xerotic scaly plaques. Laboratory workup revealed an elevated erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) with unremarkable complete blood count (CBC), complete metabolic panel (CMP), antinuclear antibody (ANA), treponema pallidum antibody, and bacterial culture swab. With no immediate need for hospital admission, punch biopsy for hematoxylin and eosin (H&E) and tissue culture was obtained and triamcinolone 0.1% cream was started. The patient was discharged home. Biopsy revealed spongiotic dermatitis with prominent papillary dermal edema and no evidence of vasculitis, vasculopathy, or infectious etiology.

At a follow up visit, the patient noted that her home furnace had broken in March of 2020, at which time she purchased a large space heater which she had been using in very close proximity to her left leg. A diagnosis of bullous erythema ab igne with superficial ulcerations was made. Management options discussed included 5-fluorouracil, topical retinoids, and lasers, all of which were declined by the patient. She was instructed to place the space heater at a distance from her left leg. Vaseline, Telfa, Kerlix, and Coban were placed over the affected leg to use until reepithelialization had taken place. Patient consent was obtained for both photography and sharing of history in this case.

Conclusion: This case highlights the broad differential and workup for livedo reticularis, and it emphasizes the importance of thorough history taking and comprehensive physical examination.

Varicella-Zoster Virus-associated Longitudinally Extensive Transverse Myelitis in an Immunocompetent Adult: An Unusual and Rare Complication of Herpes Zoster

Daniel Crespo, Amrita-Amanda Vuppala, David Semerad, John Bertoni

1University of Nebraska Medical Center, College of Medicine, Department of Neurology
2University of Nebraska Medical Center, Truhlsen Eye Institute
3Omaha VA Medical Center, Department of Radiology
4University of Nebraska Medical Center, College of Medicine, Department of Neurology, Division of Movement Disorders

Mentor: Amrita-Amanda Vuppala
Program: Neurology
Type: Case Report

Background: Herpes Zoster (HZ) occurs from reactivation of Varicella Zoster Virus (VZV) in dorsal root ganglia. Common neurological complications include cranial neuropathies and encephalitis. Longitudinally extensive transverse myelitis (LETM) has rarely been described in immunocompetent patients. We report a case of VZV-associated-LETM occurring despite a course of acyclovir for HZ.

Case: A 58-year-old immunocompetent male presented with HZ infection in right T4 dermatome. He received a course of acyclovir. Three weeks later, he developed right chest numbness attributed to post-herpetic neuralgia and received analgesics. A few days later he presented to ED with bilateral lower extremity weakness and numbness from T4 level. The initial MRI was normal. He again received acyclovir for VZV-associated myelitis despite negative imaging. CSF showed lymphocytic pleocytosis, high VZV IgG levels. Bloodwork/CSF analysis ruled out other infectious/autoimmune etiologies. Five days later, MRI was again unremarkable. He developed rapidly progressive paraplegia. Thirteen days after admission, a third MRI showed a longitudinally extensive transverse myelitis, contrast enhancing and centrally located from C7 to T4. Decreasing the echo time (TE) on the STIR sequence helped make the diagnosis. Plasma exchange was