

in 2004 and 2005.⁶ The highest number of positive reactions was seen with ketoprofen (45 cases). Promethazine occupied sixth place with 7 cases, although in none of them were the reactions considered relevant. In our experience, of the 48 photopatch tests done in the Dermatology Department of Hospital 12 de Octubre in Madrid between 1999 and 2005, 5 cases were positive for promethazine, 4 of them of unknown relevance and considered to be the result of phototoxicity.

In addition to photosensitization to promethazine, our patient developed allergic contact eczema to wool alcohols, an excipient ingredient in Phenergan cream. We found only 1 article on sensitization to an excipient of Phenergan cream, specifically to triethanolamine.⁷ Among 22 patients with positive patch test results for Phenergan cream, 4 reacted to

triethanolamine. However, we found no cases of photosensitive eczema due to an excipient of Phenergan cream reported in the literature.

In summary, in terms of delayed reactions to Phenergan cream, cases of photosensitive eczema due to promethazine considered to have current relevance are uncommon, and no cases have been found in which this diagnosis was associated with allergic contact eczema caused by the excipient ingredients of Phenergan cream.

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Unilateral Contact Dermatitis Caused by Footwear

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To the Editor:

Contact dermatitis caused by footwear is usually bilateral. It generally starts on the dorsum of the fifth toe and gradually extends to the dorsum of the foot, sparing the interdigital folds. Potassium dichromate is the most frequent

allergen. We report the case of a patient diagnosed with dermatitis caused by contact with shoe dye on 1 foot who was initially wrongly diagnosed with dermatitis artefacta.

The patient was a 64-year-old woman who consulted with an outbreak of blisters that had begun 1 month earlier and that was evenly distributed along the lateral aspects of her right foot (Figure 1). Examination revealed 2 flaccid blisters on the side of the foot resting on an erythematous base and a linear erythema on the dorsum of the foot. Residual lesions were also present. The other foot was not affected and the rest of the skin was spared. A first possible diagnosis was thought to be contact eczema, although it was strange that this did not affect both feet. The patient was taking cinitapride, domperidone, and diazepam; her basic medication was suspended but the

blisters remained. Dermatitis artefacta was also considered in the differential diagnosis. The patient had been receiving psychiatric treatment for anxiety-depression syndrome for many years. We insisted that it was strange that the lesions only affected the right foot and, during the following visit, she presented with erythema and vesiculation on the left foot that had begun a few hours earlier, and with distant lesions on her chest; furthermore, the right foot was now free of lesions for the first time. A biopsy was performed and histopathology revealed characteristics typical of acute eczema.

The patient eventually noticed that the lesions were related to the use of shoes that had been dyed 2 months previously. The dye had stained the internal sides of the right shoe (Figure 2), exactly where the blisters had



Figure 1. Blisters on the lateral aspects of the right foot with linear erythema on the dorsum of the foot. Residual lesions were also observed. No lesions were apparent on the other foot.

appeared on her foot. The patient tried her right shoe on her left foot, and after a few hours lesions appeared on the foot along with distant lesions on her chest.

Patch testing was performed with a standard series and a shoe series, the latter proving positive for 4-aminoazobenzene; however, there was no cross-reactivity with paraphenylenediamine (Figure 3). The rubber and dyed leather of the shoe were also patch tested and the reaction was positive. The definitive diagnosis was contact dermatitis caused by shoe dye. Since she stopped using the shoes, the patient has not presented further lesions.

Therefore, we describe a case of unilateral contact dermatitis caused by footwear. This atypical presentation delayed diagnosis and led us to consider different options, such as factitious dermatitis. Footwear contact dermatitis typically presents bilaterally and commonly affects the dorsa of the feet. Diagnosis is made difficult by the existence of atopic dermatitis and pre-existing or overlapping infection. Moreover, other conditions that can be misdiagnosed, such as nummular eczema, tinea pedis, dyshidrotic eczema, contact dermatitis caused by topical medication, etc.^{1,2}

4-Aminoazobenzene is an intermediate in the production of diazo dyes used in the textile and footwear industry. Cross-sensitivity between azo dyes and para-amino compounds such as phenylenediamine is common,^{3,4} although in our case we did not observe cross-reactivity.



Figure 2. Right shoe. The ink had stained the internal sides of the shoe in the area where the patient presented the blisters.



Figure 3. Positive patch test with 4-aminoazobenzene.

Since the year 2000, the Contact Unit of the Dermatology Service of Hospital General Universitario in Valencia, Spain, has recorded 82 cases of contact dermatitis due to footwear. As was the case in other series,⁵ potassium dichromate was the most common allergen (86.5%), and other less commonly involved allergens were 4-tert-butylphenol-formaldehyde resin, 2-mercaptobenzothiazol, nickel, and paraphenylenediamine. Only 2 of our cases involved aminoazobenzene, and in 1 there was cross-reactivity with paraphenylenediamine. The mean age of diagnosis was 34 years and the ratio of men to women was 1:3. This dermatitis presented most commonly on the dorsa of the feet. The conditions diagnosed before contact dermatitis were dyshidrotic eczema, neurodermatitis, lichen simplex chronicus, psoriasis, and dermatitis artefacta, as in our case.

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Two Cases of Hypertrichosis Cubiti

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To the editor:

Hypertrichosis cubiti, also known as hairy elbows syndrome, is an uncommon form of localized congenital hypertrichosis in

which an excessive amount of long, fine, lanugo-type hair is found on skin of normal texture and morphology. The hair growth follows a bilateral symmetrical

distribution and affects the extensor surface of the distal third of the upper arms and the proximal region of the forearms. The condition usually appears