

Severe Foot Dyshidrotic Eczema

Eczema Disidrótico Grave dos Pés

Catarina Benvinda Ferreira, Luís Paulo Costa

Autor Correspondente/Corresponding Author:

Catarina Benvinda Ferreira [cbaf@edu.ulisboa.pt]

ORCID: <https://orcid.org/0009-0009-9579-0474>

Medicina Geral e Familiar, Unidade Local de Saúde Estuário do Tejo, Unidade de Saúde Familiar Lusitano, Arruda dos Vinhos. Portugal.

Av. Eng. Adriano Brito Conceição, N° 6, 2630-299 Arruda dos Vinhos

DOI: <https://doi.org/10.29315/gm.1025>

PALAVRAS-CHAVE: Eczema Disidrótico; Úlcera do Pé

KEYWORDS: Eczema, Dyshidrotic; Foot Ulcer

A 51-year-old woman with no relevant medical history presented with an exuberant bullous rash on both feet, with a 2-month evolution. The lesions were limited to the plantar surfaces, with areas of scaling, particularly in the interdigital spaces. Extended itching, pain on touch, and feeling of heat were referred. The patient's job requires her to use steel-toe boots daily.

Initially, the patient was treated for fungal infection with no improvement. Advised to avoid work boots was given. After 5 days of treatment with local and systemic corticosteroid therapy (prednisolone 20 mg and clobetasol propionate 0.5 mg/g daily), the symptomatology improved significantly.

The estimated prevalence of dyshidrotic eczema in adults ranges from 0.05% to 10.6%.¹ Diagnosis is clinical, based on history and physical findings, and thus histopathology was not deemed necessary.² Dyshidro-



FIGURE 1. Bullous dyshidrotic eczema on right sole.

tic eczema may be triggered by allergic or irritant contact, such as occupational exposure. In this case, the episode occurred during the summer, and although the lesions persisted even when the patient was away from the workplace, there was a clear worsening of symptoms associated with the use of steel-toe boots, suggesting that while occupational exposure was a

Medicina Geral e Familiar, Unidade Local de Saúde Estuário do Tejo, Unidade de Saúde Familiar Lusitano, Arruda dos Vinhos. Portugal.

Recebido/Received: 2025-03-12; Aceite/Accepted: 2025-08-26; Publicado online/Published online: 2025-10-08

© Author(s) (or their employer(s)) and Gazeta Médica 2025. Re-use permitted under CC BY-NC 4.0. No commercial re-use.

© Autor (es) (ou seu (s) empregador (es)) e Gazeta Médica 2025. Reutilização permitida de acordo com CC BY-NC 4.0. Nenhuma reutilização comercial



FIGURE 2. Bullous dyshidrotic eczema on left sole.

significant trigger, other factors may also have contributed. Patch testing for allergens (e.g., rubber, glues, chromium, metals) was not performed, as the diagnosis was clinical and such tests are not readily available in primary care.

Following initial remission, the patient experienced a relapse two months later. Despite consultation with occupational health services regarding alternative footwear, a change was not possible. The lesions regressed with corticosteroid therapy but recurred after cessation, indicating a chronic, relapsing course with professional implications. Avoidance of triggers and topical corticosteroids remain the first-line management for flares.

DECLARAÇÃO DE CONTRIBUIÇÃO /CONTRIBUTORSHIP STATEMENT

CBF - Elaboração do manuscrito

LPC - revisão do manuscrito

Todos os autores aprovaram a versão final a ser publicada.

CBF - Manuscript preparation

LPC - Manuscript review

All authors approved the final version to be published.

RESPONSABILIDADES ÉTICAS

CONFLITOS DE INTERESSE: Os autores declaram a inexistência de conflitos de interesse na realização do presente trabalho.

FONTES DE FINANCIAMENTO: Não existiram fontes externas de financiamento para a realização deste artigo.

CONFIDENCIALIDADE DOS DADOS: Os autores declaram ter seguido os protocolos da sua instituição acerca da publicação dos dados de doentes.

CONSENTIMENTO: Consentimento do doente para publicação obtido.

PROVENIÊNCIA E REVISÃO POR PARES: Não comissionado; revisão externa por pares.

ETHICAL DISCLOSURES

CONFLICTS OF INTEREST: The authors have no conflicts of interest to declare.

FINANCING SUPPORT: This work has not received any contribution, grant or scholarship.

CONFIDENTIALITY OF DATA: The authors declare that they have followed the protocols of their work center on the publication of patient data.

PATIENT CONSENT: Consent for publication was obtained.

PROVENANCE AND PEER REVIEW: Not commissioned; externally peer-reviewed.

REFERENCES

1. Soler DC, Bai X, Ortega L, Pethukova T, Nedorost ST, Popkin DL, et al. The key role of aquaporin 3 and aquaporin 10 in the pathogenesis of pompholyx. *Med Hypotheses*. 2015;84:498-503. doi: 10.1016/j.mehy.2015.02.006.
2. Wollina U. Pompholyx: a review of clinical features, differential diagnosis, and management. *Am J Clin Dermatol*. 2010;11:305-14. doi: 10.2165/11533250-000000000-00000.