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Atypical presentation of textile dye sensitization

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Contact allergy to textile dyes is not very common, with a frequency ranging from 1.4 to 5.8% (1). Typically, such allergic reactions are acute or subacute dermatitis at sites of friction and in major skin folds. However, patients may present a varied clinical picture, including urticaria, diffuse pruritus, and erythema-multiforme-like eruption (2).

Case Report

A 46-year-old woman, with no history of atopic dermatitis, developed a pruritic eruption on the postero-medial thighs. Initial examination in December 1994 revealed infiltrated erythematous lesions evoking cold panniculitis. Skin biopsy showed lichenification with moderate lymphocytic infiltration of the superficial dermis. Despite topical corticosteroid, the lesions worsened and spread, some mimicking erythema multiforme. The patient noted an aggravation of her dermatitis by the end of the working week. By February 1995, a large infiltrated eruption, with induration of the edges, involved the buttocks and posterior thighs, a mild maculopapular eruption being present on the abdomen. On stopping corticosteroid, the lesions extended with peripheral superficial exfoliation. A 2nd biopsy revealed an eczematous picture. When asked, the patient indicated aggravation of her dermatitis when wearing dark tights or skirt for working.

Patch testing was performed with the European standard and a textile dyes series and was positive (++) to cobalt, nickel, Disperse Blue 106 and 124 (2 and 4 days). Avoidance of dark clothes produced rapid recovery.

Comment

This case of allergy to Disperse Blue 104 and 126, the strongest dye sensitizers to date, is unusual because of its atypic clinical presentation (3, 4). The severe infiltration, with annular enhancement, delayed diagnosis. Pseudolymphoma and erythema-multiforme-like presentations have previously been described with azo dyes (2, 5, 6). Doms-Gossens (5) noted that monomorphic and infiltrated dermatitis (dermal reaction) was particularly observed with Disperse Blue 106. In our case, the corticosteroid had probably hidden the epidermal signs and explained the pseudolymphoma appearance. As stated by Seidenari et al. (7), the diagnosis of textile dye contact dermatitis is often delayed because of unusual clinical presentation, and it is usually *after* patch testing that clothing is identified as causative.

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