

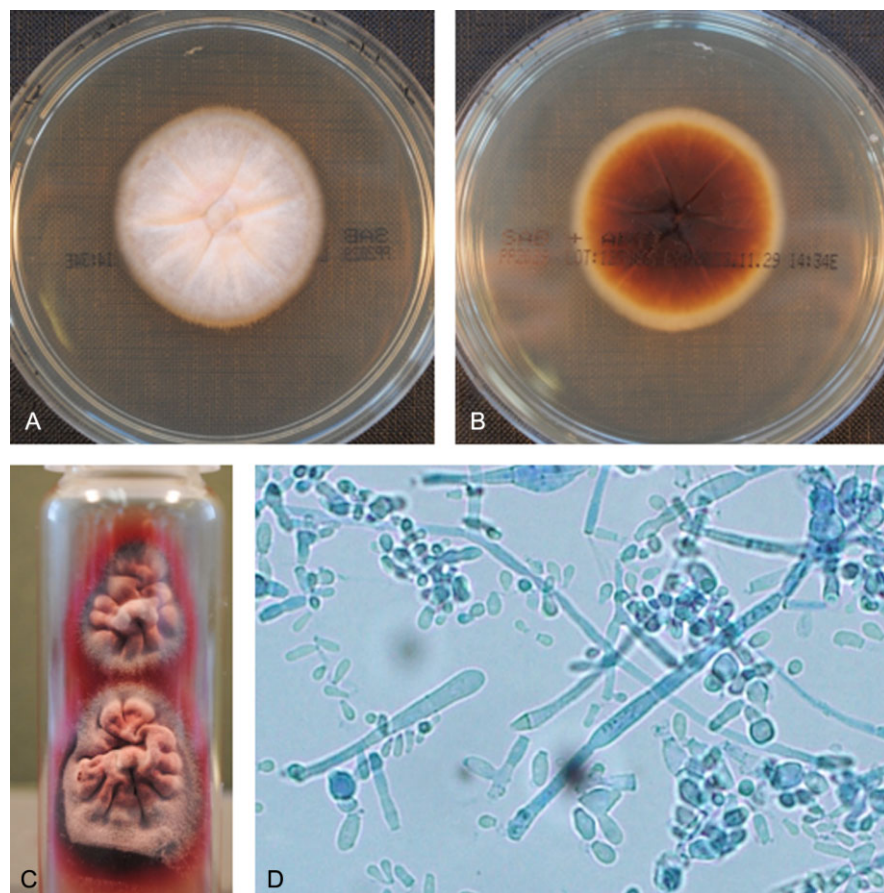


Figure 2 Morphological features of the neonate *Trichophyton rubrum* isolate showing (a) white to cream suede colony following 14-days' growth on Sabouraud dextrose agar with (b) reddish-brown reverse pigment; (c) heaped and folded pink to grey colony on potato dextrose agar with distinctive pink-red reverse pigmentation; (d) microscopic characteristics including hyaline hyphae with terminal and intercalary chlamydospores, microconidia including enlarged balloon forms and thin-walled cylindrical to irregularly shaped multiseptate macroconidia.

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Dear Editor,

Allergic contact dermatitis following epoxy resin exposure to a paint in a recreational setting

We would like to highlight a case of allergic contact dermatitis caused by epoxy resin exposure in an unusual

recreational setting. This case involved a middle-aged woman whose hobby was painting.

The patient was using a two-part resin, Glass Coat resin (CraftSmart, Melbourne, Victoria, Australia) as part of her recreational painting. Her routine included mixing the resin by tipping it into a closed container and then pouring it into the paint. She generally alternated between wearing disposable and reusable vinyl gloves for protection, as she had been previously diagnosed with latex allergy. After preparing the mixture she would tip the product onto a canvas, creating the possibility of airborne exposure.

On presentation to the clinic she had marked eyelid dermatitis. She was extensively patch tested to our extended European standard series and to samples of her own products, although she did not bring the resin for testing. Testing was performed using Finn Chambers on Scanpor Tape (SmartPractice, Phoenix, AZ, USA), applied to the patient's back for 48 hours. Tests were read at day 2 and day 4. She had positive reactions to epoxy resin, methylchloroisothiazolinone and methylisothiazolinone, formaldehyde, thiuram mix, carba mix and gold sodium thiosulphate. The product packaging and material safety data sheet listed bisphenol A epoxy resin as an ingredient.

The diagnosis made was (i) allergic contact dermatitis to epoxy resin in her Glass Coat resin and (ii) allergy to methylchloroisothiazolinone and methylisothiazolinone,

formaldehyde, thiuram mix, carba mix and gold sodium thiosulphate, with no relevant exposure identified at all for these allergens. The patient improved with the avoidance of the allergen.

Of particular interest was the fact that the patient had not received any advice on how to protect herself when using the resin, nor was she informed of its potentially harmful effects when purchasing the product. The safety data sheet was somewhat vague and non-specific in the warnings, naming 'irritation' as a possible skin effect, and 'dermatitis' as a possible chronic effect.

Enquiries were made to the distributors of the product as well as to the suppliers of the material safety data sheets, ChemQuest (Melbourne, Victoria, Australia). The distributors and suppliers were informed of the case and advised to improve their information on its potential hazards to consumers wanting to use this product. Despite this informed advice, no update or alteration of the safety data sheet was made until the company was again approached on a later occasion. At this point the data sheet was appropriately improved. The direct website of the Glass Coat resin product also failed to include adequate warnings to customers. The site redirected clients seeking safety advice to the ChemQuest website for information through online material safety data sheets.¹

Epoxy resins are well known to be a common cause of allergic contact dermatitis and are strong sensitizers.² Eyelid dermatitis is also a feature of allergic contact dermatitis to epoxy resins and hardeners as they may be volatile.^{3,4} A recent study conducted in Finland concluded that non-occupational exposure is not uncommon and advised that more detailed product information should be available for epoxy chemicals commonly used recreationally for hobbies, self-performed construction and repair projects.⁵ Similarly, a case series reported from Melbourne also involved recreational exposure to allergens more commonly associated with occupational exposures, namely, isocyanates in the manufacture of jewellery.⁶ Consumers may be unaware of the need to check data sheets, whereas this is standard practice in the workplace setting.

This case draws attention to the fact that contact allergy can occur in any setting and that a thorough and exploratory history is often the key to identifying which allergens to test for, and therefore the key to reaching the final diagnosis. Finally, it highlights the difficulties that arise when data sheets are inadequate⁷ and reinforces the fact that it is necessary to check that suppliers have actually acted on advice given to improve safety warnings.

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Dear Editor,

Discoid lupus Erythematosus-Associated Koebnerization at the Site of Healed Herpes Zoster

A 79-year-old man presented with scale-covered, non-painful red plaques that had appeared on the medial area of his right thigh 20 days earlier. Clustered erythema and vesicles had developed in the same position 1 month previously, accompanied by severe pain. This was diagnosed as herpes zoster and he had received antiviral therapy for 2 weeks. The skin lesions rapidly cleared but the pain did not ameliorate. The patient had suffered from (DLE) for over 5 years. A physical examination revealed a few dull red plaques on the medial aspect of his right thigh, measuring 2–4 mm in diameter and covered by tiny scales (Fig. 1). Similar lesions were present on non-affected areas, predominantly the extremities and buttocks. The physical examination was otherwise unremarkable. Immunological studies revealed antinuclear antibodies 1:1000 with a Golgi apparatus pattern and positive anti-SSA antibody staining. The full blood count and urine analyses were within normal limits. A chest X-ray and abdominal ultrasound were unremarkable. The histopathological examination of specimens from the right thigh was consistent with DLE. Based on these findings, a diagnosis was made of DLE that exhibited the Koebner phenomenon. The patient commenced treatment with oral traditional Chinese medicine and topical corticosteroids for 2 months. The skin lesions completely resolved.

The Koebner (isomorphic) phenomenon was first reported by Heinrich Koebner in 1876.¹ This finding indicates the appearance of typical skin lesions of an existing dermatosis in previously normal skin following an injury. The predisposing factors for the Koebner phenomenon have been reported to be needling, scratches and scars,² but reports of areas of DLE that exhibit the Koebner

Abbreviation:

DLE discoid lupus erythematosus