

CONTACT POINT

"It's not lupus, it's your nails!"

Siobhan McCarthy  | Aoibheann Flynn | Mary Bennett | John F. Bourke

Department of Dermatology, South Infirmary Victoria University Hospital, Cork, Ireland

Correspondence

Dr Siobhan McCarthy, Dermatology Department, South Infirmary Victoria University Hospital, Cork, Ireland.
Email: siobhanmcc@gmail.com

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CASE REPORT

A 22-year-old female patient presented with intermittent erythematous plaques present on the face and neck in a photo-distributed pattern. She reported no significant past medical history, but had a positive family history of systemic lupus erythematosus affecting her maternal aunt. A biopsy of the facial rash was undertaken, and showed subacute spongiotic dermatitis with a lymphocytic perivascular inflammatory infiltrate and dermal mucin. The histology was equivocal, but the presence of mucin prompted a diagnosis of lupus erythematosus, despite negativity for anti-nuclear antibody. The patient was treated over the next year with hydroxychloroquine, prednisolone, and mycophenolate mofetil, with partial success. The rash spread to the trunk and lower limbs, and continued to intermittently flare, prompting a repeat biopsy. A biopsy taken from the right upper back showed pityriasiform and spongiotic dermatitis with no features of psoriasis or lupus. On review at a departmental meeting, the patient was felt to have psoriasis or dermatitis, and patch testing was suggested to rule out allergic contact dermatitis (Figure 1).



FIGURE 1 Erythematous plaques on the posterior neck and back

Patch testing was performed with the British Society of Cutaneous Allergy baseline, facial, medicament and steroid series. 2-Hydroxyethyl-1-methacrylate (2-HEMA) 2% pet. gave a positive reaction on day 2. The (meth)acrylate series was added, and gave positive reactions to ethyl cyanoacrylate, bisphenol A glycidyl dimethacrylate, and butanediol dimethacrylate. The patient reported intermittent use of "press-on" artificial nails, and was advised to avoid nail glue and acrylate-containing nail products in future. Her rash resolved shortly after patch testing, and her systemic therapy was discontinued. On follow-up, she remained symptom-free.

DISCUSSION

Allergy to acrylates (comprising also methacrylates and cyanoacrylates) has become an increasingly common problem.¹ Traditionally, exposure was occupational; however, current trends in the use of ultraviolet-cured acrylate-containing nail products and artificial nails have resulted in a sharp increase in the number of cases of non-occupational hand and facial dermatitis.¹ Given the current epidemic of acrylate allergy, clinicians should be aware of this possibility as a differential diagnosis in exposure/photo-distributed pattern rashes. This highlights the importance of recognizing and testing for contact allergy to acrylates in at-risk populations, and supports the inclusion of 2-HEMA in the standard series.

CONFLICT OF INTEREST

The authors declare no potential conflict of interests.

ORCID

Siobhan McCarthy  <http://orcid.org/0000-0002-1098-2963>

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