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Unilateral Livedoid Hyperpigmentation of the Lower Extremity

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proximal medial tibial plateau were present. He had positive Thessaly and non-painful crepitus with McMurray maneuvers. He was unable to complete a squat or full AROM due to pain. MRI knee revealed acute non-displaced proximal tibial metaphysis fracture-likely insufficiency fracture, joint effusion, and DJD.

Patient was made NWB and placed in hinged knee brace locked in full extension for 3 weeks and then progressive WB and ROM as typical for tibial plateau fracture management. Calcium &Vit D supplementation was prescribed, and the patient was referred to endocrinology for bone health optimization. Patient consent was obtained in order to use this information for education purposes.

Conclusion: Bariatric surgery has known risk of negatively affecting bone health. Different types of procedures have expressed variable levels of risk and other factors including gender and vitamin regimens can affect long term sequela. Compliance and follow up could have potentially prevented this patient's fracture and overall morbidity, reinforcing their importance. ■

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Unilateral Livedoid Hyperpigmentation of the Lower Extremity

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Mentor: Ashley Wysong

Program: Dermatology

Type: Case Report

Background: Erythema ab igne is a clinical diagnosis that comes with a broad differential diagnosis. Thorough history taking and ruling out of other reticulate dermatoses enables for its diagnosis. It is most often seen in cases of prolonged exposure to heat (space heater, laptop usage, heating blankets).

Case: A 40-year-old female with past history of livedo reticularis, hypertension, type II diabetes, obesity, and traumatic brain injury presented to the emergency department with a 1-month history of left lower extremity rash, edema, and bullae. She denied any remote history of intravenous drug use or chronic heat exposure. Recent outpatient workup for livedo reticularis revealed no evidence of venous/arterial insufficiency or deep venous thrombosis. Examination demonstrated net-like violaceous patches consistent with livedo reticularis, some non-blanchable, over the left lower extremity. Overlying, there were several tense bullae with clear fluid and other deroofed bullae as well as xerotic scaly plaques. Laboratory workup revealed an elevated erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) with unremarkable complete blood count (CBC), complete metabolic panel (CMP), antinuclear antibody (ANA), treponema pallidum antibody, and bacterial culture swab. With no immediate need for hospital admission, punch biopsy for hematoxylin and eosin (H&E) and tissue culture was obtained and triamcinolone 0.1% cream was started. The patient was discharged home. Biopsy revealed spongiotic dermatitis with prominent papillary dermal edema and no evidence of vasculitis, vasculopathy, or infectious etiology.

At a follow up visit, the patient noted that her home furnace had broken in March of 2020, at which time she purchased a large space heater which she had been using in very close proximity to her left leg. A diagnosis of bullous erythema ab igne with superficial ulcerations was made. Management options discussed included 5-fluorouracil, topical retinoids, and lasers, all of which were declined by the patient. She was instructed to place the space heater at a distance from her left leg. Vaseline, Telfa, Kerlix, and Coban were placed over the affected leg to use until reepithelialization had taken place. Patient consent was obtained for both photography and sharing of history in this case.

Conclusion: This case highlights the broad differential and workup for livedo reticularis, and it emphasizes the importance of thorough history taking and comprehensive physical examination. ■

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Varicella-Zoster Virus-associated Longitudinally Extensive Transverse Myelitis in an Immunocompetent Adult: An Unusual and Rare Complication of Herpes Zoster

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Type: Case Report

Background: Herpes Zoster (HZ) occurs from reactivation of Varicella Zoster Virus (VZV) in dorsal root ganglia. Common neurological complications include cranial neuropathies and encephalitis. Longitudinally extensive transverse myelitis (LETM) has rarely been described in immunocompetent patients. We report a case of VZV-associated-LETM occurring despite a course of acyclovir for HZ.

Case: A 58-year-old immunocompetent male presented with HZ infection in right T4 dermatome. He received a course of acyclovir. Three weeks later, he developed right chest numbness attributed to post-herpetic neuralgia and received analgesics. A few days later he presented to ED with bilateral lower extremity weakness and numbness from T4 level. The initial MRI was normal. He again received acyclovir for VZV-associated myelitis despite negative imaging. CSF showed lymphocytic pleocytosis, high VZV IgG levels. Bloodwork/CSF analysis ruled out other infectious/autoimmune etiologies. Five days later, MRI was again unremarkable. He developed rapidly progressive paraplegia. Thirteen days after admission, a third MRI showed a longitudinally extensive transverse myelitis, contrast enhancing and centrally located from C7 to T4. Decreasing the echo time (TE) on the STIR sequence helped make the diagnosis. Plasma exchange was