Sir,

A 55-year-old obese female with type 2 diabetes presented with a painless ulcer over the gluteal region of 3 months duration. Patient also complained of pruritic perianal cutaneous eruption, for which she had been applying an over-the-counter mixed cream (clobetasol propionate and clotrimazole combination) twice daily for the last 6 months. There was no history of trauma, weight loss, or decreased appetite. No complaints of diarrhea, hematochezia, urinary or fecal incontinence; no history of recent sexual contact. Apart from metformin, she was not on any other medications.

On examination, on the inner aspect of left gluteal region, there was a single well-defined ulcer (1 × 1 cm) with a punched out edge, with raised hyperpigmented border, indurated base and floor containing pale granulation tissue with some serous discharge. Surrounding skin was shiny, hypopigmented with faint erythema and visible telangiectasia. On the right gluteal region, in apposition to the ulcer, there was a scaly, annular, erythematous plaque (5 × 5 cm) clinically resembling tinea [Figure 1]. Regional lymph nodes were not palpable. There were no other mucocutaneous findings. Differential diagnoses considered were Crohn’s disease, periorificial tuberculosis, metastatic or primary cutaneous neoplasm, syphilis, and Jacquet’s erosive dermatitis (JED), and routine and specific investigations were sent.

Potassium hydroxide (KOH) mount from the scaly plaque showed fungal hyphae consistent with tinea corporis. Routine blood and urine tests were normal. HIV, hepatitis B, C, and serologic tests for syphilis were negative. Chest X-ray was unremarkable; Mantoux test was negative. Colonoscopy study was normal. Biopsy from edge of ulcer revealed stratified squamous epidermis with marked hyperkeratosis, parakeratosis, acanthosis, and ulceration on one side. Dermis showed dense mixed perivascular inflammatory infiltrate consisting of neutrophils and lymphocytes [Figure 2].

Considering the clinical presentation, nonspecific histopathological findings, and signs of local steroid abuse, a diagnosis of JED was made. The tinea lesions became more evident on first follow-up after 7 days [Figure 3]. The patient was prescribed oral itraconazole (100 mg) and topical eberconazole cream twice daily for a month for tinea, topical mupirocin and petrolatum jelly for the ulcer, with strict advice to avoid topical steroid cream application.

JED represents a severe form of irritant contact dermatitis (ICD), commonly due to diaper use, characterized by punched out ulcers with raised borders.[1] Characteristically histologic findings are nonspecific; therefore, diagnosis is mostly clinical.[2] Treatment involves withdrawing causative factors and emollients. The lesions usually heal spontaneously with hyperpigmentation and atrophic scarring. Close differentials are granuloma gluteal infantum/adultorum (GGI/GGA) and pseudoverrucous papules and nodules (PPPN), which are believed to be a spectrum of chronic ICD of the genital area.[3] The salient differences in causative factors and clinical and histological features are elaborated in Table 1. Our patient did not have a history of prior nodule and histology revealed mixed perivascular...
Topical corticosteroid use is a double-edged sword as indiscriminate use leads to untoward complications. Factors dictating side effects are prolonged use, potency, vehicle, and application site. Our patient continuously applied potent corticosteroid over the tinea plaque for 6 months twice daily, leading to inadvertent application on the opposite healthy gluteal skin. Perilesional hypopigmentation, atrophy, and telangiectasia were added evidence of topical steroid abuse.

Chronic scratching due to tinea could have led to superficial erosions, followed by local bacterial flora overgrowth leading to further ulcer enlargement. Steroid-induced atrophy, loss of barrier function, occlusion, and friction all contributed to the development and persistence of ulcer.

Previously reported cases of ulceration due to topical steroid abuse have findings dissimilar to our case of Jacquet's dermatitis. Perianal ulcer has been reported once previously; however, the ulcers were deep, symmetrical, with erythematous borders that were not raised. Another case series described superficial ulcers in the mammary area having erythema and atrophy in the surrounding skin.

The clinically ambiguous presentation in the perianal region can be mistaken for a grave diagnosis, especially in elderly individuals. With the ongoing unregulated use of mixed creams for superficial dermatophytosis, such a presentation may be encountered. Keeping in mind this rare entity can help obviate a long array of investigations, diagnostic delay, and aid management.

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**Conflicts of interest**

There are no conflicts of interest.
Table 1: Salient Differentiating features of GGA, PPPN, and JED

| Causative factors                                      | Granuloma gluteal adullorum (GGA) | Psuedoverrucous papules and nodules (PPPN) | Jacquet’s erosive dermatitis (JED) |
|--------------------------------------------------------|-----------------------------------|------------------------------------------|-----------------------------------|
| Occlusion, starch-containing powders, topical halogenated steroids | In perianal areas secondary to urinary incontinence and encopresis as a form of irritant contact dermatitis |                               | Chronic irritant dermatitis to infrequent diaper changing and diaper detergents. |
| Candida infections, urine and feces.                   |                                   |                                          | Contributory factors are friction, maceration, occlusion with bacterial colonization. |
| In occulted areas                                      | Shiny, smooth, red moist, flat-topped, and round papules                              | Punched out ulcers with elevated borders |
| Epidermal hyperplasia, dense mixed superficial and deep inflammatory infiltrate, dilation and proliferation of blood vessels. | Spongiotic psoriasiform acanthosis, no significant dermal inflammation            | Nonspecific histological findings |

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