A 28-year-old lady (ENT resident) presented with asymptomatic brown patch on the left palm of 1-week duration. She denied history of contact with chemicals/plants, intake of drugs, or local application of mehendi (plant paste used for beautification of hands). She was immunocompetent and not a diabetic. Examination of the left palm revealed two linear hyperpigmented patches, one in the middle of the palm and the other occupying the distal palmar crease [Figure 1]. Scaling was minimal. Other areas including body folds were not involved. Teeth were normal. Wood’s lamp examination of the left palm showed coral red fluorescence corresponding to the hyperpigmented patches and extending on to the palmar aspect of the index finger [Figure 2]. There was no fluorescence of teeth and urine on Wood’s lamp examination. Scraping from the patch did not reveal any bacteria or fungal elements. Serology for venereal disease research laboratory test and human immune deficiency virus was nonreactive. She was diagnosed as erythrasma and was given a week course of erythromycin which cleared the patches [Figure 3]. The disappearance of pigmented patches following a course of erythromycin and the absence of coral red fluorescence on Wood’s lamp examination post-treatment substantiate the diagnosis of erythrasma [Figure 4].

Erythrasma is a chronic superficial infection of intertriginous areas of skin caused by Corynebacterium minutissimum. The incidence of erythrasma reported in literature is around 4%. It is known to occur all over the world and is found more frequently in tropical and subtropical regions. Clinically, it manifests as brownish discoloration of skin usually limited to body folds such as crural region, submammary region, axillae, and intergluteal folds. The occurrence of erythrasma in the index case appears to be unique and rare as literature search did not reveal any such presentation. It is usually asymptomatic, but mild burning or itching may be present. Predisposing factors for erythrasma include diabetes.
mellitus, hyperhidrosis, obesity, warm climate, poor hygiene, and immunocompromised states. However, there were no predisposing factors attributable in the index case. There are two distinct variants of erythrasma: generalized and interdigital. The interdigital is the most common type that presents with fissuring and scaling involving interdigital spaces of toes. The generalized variant is commonly seen in diabetics in whom the skin lesions extend beyond interdigital areas. Pityriasis versicolor can be differentiated from erythrasma by the presence of satellite lesions in the former. Other differential diagnosis includes intertrigo, flexural psoriasis, seborrheic dermatitis, and tinea cruris.[2-3] Wood’s lamp examination of the lesion reveals coral red fluorescence,[4] which is due to excess production of coproporphyrin by diphtheroids. Gram stain of scraping from erythrasma lesions reveals Gram-positive filamentous rods.

Erythrasma may be treated with topical and/or systemic agents. Topical therapeutic agents include erythromycin, clindamycin, fusidic acid, and miconazole. Erythromycin and clarythromycin may be used systemically in erythrasma.[5]

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Conflicts of interest
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References
1. Sarkany I, Taplin D, Blank H. Incidence and bacteriology of erythrasma. Arch Dermatol 1962;85:578-82.
2. Aste N, Pau M, Aste N. Pityriasis versicolor on the groin mimicking erythrasma. Mycoses 2004;47:249-51.
3. Marinella MA. Erythrasma and seborrheic dermatitis of the groin. Am Fam Physician 1995;15:2012.
4. Schwartz RA, Al Mutairi N. Topical antibiotics in dermatology: An update. Gulf J Dermatol Venerol 2010;17:1-19.
5. Turk BG, Turkmen M, Aytimur D. Antibiotic susceptibility of Corynebacterium minutissimum isolated from lesions of Turkish patients with erythrasma. J Am Acad Dermatol 2011;65:1230-1.