observed several new large dark purple ecchymosis on the trunk and limbs. Routine blood test and blood coagulation showed no changes. With treatment following the recommended zinc dosage for 5 days, the ecchymosis on the trunk and limbs subsided, the ulcer healed, and the perineal erythema receded (Figure 2).

Causes of acquired zinc deficiency include inadequate intake, parenteral nutrition, pregnancy and lactation, extensive burns, exfoliative dermatitis, intestinal malabsorption syndromes, cystic fibrosis, alcoholism, HIV infection, malignancies, and chronic renal disease. Clinical manifestations may present as psoriasiform, annular, or crusted plaques, with decreased hair and nail growth. Zinc levels either in plasma or serum are not reliable indicators for establishing a diagnosis of zinc deficiency. Normal values may be obtained in the presence of subclinical zinc deficiency. Therapeutic response in suspected cases remains the gold standard for diagnosis.

The diagnosis of acquired zinc deficiency is often missed. In the present case, based on the fungus culture of Candida albicans, the patient was misdiagnosed with candidal intertrigo. The lesion showed no improvement with treatment based on antifungal shampoo and cream. Combining the history of fasting and perineal erythema, we changed treatment regimen to zinc based on the experience we had with another adult patient with acquired zinc deficiency due to long-term parenteral nutrition. The recommended dosage of zinc is 2mg/kg/d, but the actual dosage is usually below that. In the present and previous cases, the average dosage was 0.68mg/kg/d and 0.12mg/kg/d, respectively. Both patients responded well to treatment.

Our cases have all been inpatients, most of them with a history of parenteral nutrition or diarrhea. The main complaint reported was perineal erythema. On a detailed physical examination, acral erythema and paronychia could also be observed. Although our patients’ zinc levels were normal, they all responded to zinc therapy. Inadequate dosing of zinc only partially improved the lesions. Increasing the dose led to the full resolution of the lesions, which underscores the importance of sufficient doses to confirm the diagnosis and to completely resolve the lesions.

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standard tray including cosmetics) and, at the 96-hour reading, it was positive for thimerosol (1+) and nickel sulfate (1+). Tretinoin was tested at 0.005% and 0.01% in an alcohol solution and 0.05% in vaseline. The test was positive for the 0.05% concentration only, with a reaction intensity of 1+ in both readings at 48 and at 96 hours.

The occurrence of a high intensity and a rapid onset of a dermatitis condition, with the formation of vesicles and blisters after the tretinoin peeling is still a relatively unknown event. No similar case has been reported in prior literature. Standardization of tretinoin patch testings is defective due to the irritating nature of retinoic acid. Different tretinoin concentrations were used in some case reports.4,6 Despite its exuberance, the onset of this condition took place before 24 hours after the peeling application, and tretinoin positivity was only observed at the highest concentration, which maintained the same intensity of 1+ at the 48- and 96-hour readings, which suggests irritant contact dermatitis. Patient has been under dermatology follow-up, using topical medications, and submitted to salicylic acid peeling at 30%, without intercurrent events. Despite the intense adverse reaction, patient progressed to full recovery.

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