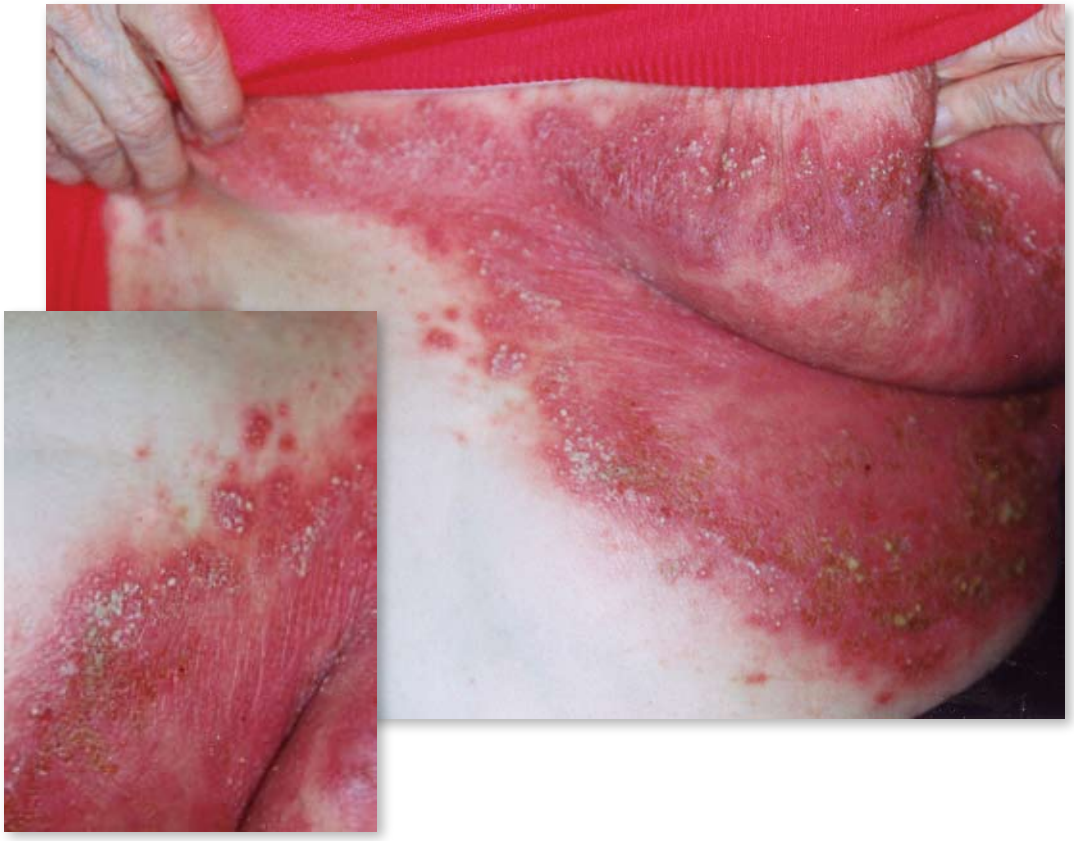

Can you identify this skin condition?

Sunil Kalia, MD **Stewart Adams,** MD, FRCPC

A 50-year-old patient presents with a red rash that contains surrounding pustules and vesicles.

The most likely diagnosis is:

1. **Pustular psoriasis**
2. **Impetigo**
3. **Sneddon–Wilkinson disease**
4. **Candidal intertrigo**

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3. Sneddon–Wilkinson disease

Prevalence of Sneddon-Wilkinson disease, also known as subcorneal pustular dermatosis, is highest among middle-aged women. This chronic, relapsing disease presents as pustules and vesicles that move peripherally, forming an annular pattern.[1] The flexural and intertriginous areas are most commonly affected. Pathogenesis of this disease is related to increased production of tumour necrosis factor-α, which leads to neutrophil infiltration of the skin. Although a benign condition, Sneddon-Wilkinson disease is associated with myeloma and other gammopathies. Other conditions that might be present include pyoderma gangrenosum, rheumatoid arthritis, systemic lupus erythematosus, hypothyroidism, hyperthyroidism, Crohn disease, and apudoma.[2]

Sneddon-Wilkinson disease resembles several other conditions, such as pustular psoriasis, impetigo, and candidal intertrigo.[2,3] Whether Sneddon-Wilkinson disease is a less severe variant of pustular psoriasis is an ongoing controversy. Patients with pustular psoriasis, however, usually seem more ill and might be febrile. A generalized or patch erythema contains interfollicular pustules in an annular or nonspecific configuration. These lesions usually present on the trunk and extremities. Impetigo initially presents as fragile bullae, but the roofs of the bullae quickly come off, leaving behind erosions with a peripheral collarette of scale. Candidal intertrigo is linked to moisture, heat, and friction that lead to maceration and erythema. Infection can produce vesicopustules, bright erythema, and superficial erosions surrounded by peripheral scaling. The differentiating features of candidal intertrigo include satellite pustules. Suspected cases might require potassium hydroxide testing or fungal culture.

First-line treatment for Sneddon-Wilkinson disease is 50 to 200 mg of dapsone.[4] In some cases, however, dapsone might not have an effect, and its use is limited owing to its toxicity. Sulfapyridine therapy (1 g given 4 times daily) is an alternative. Retinoids, such as acitretin and etretinate, are also appropriate for cases not responding to dapsone therapy. Other possible treatments include narrowband UVB phototherapy, corticosteriods, colchicines, tetracyclines, and tumour necrosis factor-α inhibitors.

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