Dermatology Practical & Conceptual

Dermoscopic Hallmarks of Phytophotodermatitis: A Distinctive Pattern for Differential Diagnosis

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Case Presentation

A 42-year-old horticulturist presented with acute-onset erythematous plaques involving the face, décolleté, and dorsal hands, arising 48 hours after contact with unidentified vegetation and sun exposure. Lesions were sharply demarcated, edematous,and evolved into hyperpigmented macules with petechiae. No pruritus or systemic symptom was reported. Dermoscopy revealed a red-orange background with clusters of hemorrhagic dots and globules, suggestive of phototoxic-microvascular damage. These structures were grouped irregularly, lacking the organized vascular patterns typical of immune-mediated eruptions. A fine whitish reticulated pattern was visible in inflamed areas, correlating with papillary dermal alteration. Notably, a fine, non-homogeneous desquamation was observed, asymmetrically distributed across the lesion surface, more prominent at the periphery and absent in central zones, indicating a focal disruption of the stratum corneum (Figure 1) [1]. In contrast, eczematous dermatitis commonly displays a pale pink background, yellow sero-crusts, diffuse white scales, and dotted or linear vessels arranged in clusters. These features were not present in this case, reinforcing a diagnosis of phytophotodermatitis [2].

Teaching Point

The dermoscopic pattern of a red-orange background, grouped hemorrhagic globules, white reticular streaks, and asymmetric fine desquamation is characteristic of phytophotodermatitis. Recognition of these features enables distinction from eczema and guides appropriate management.

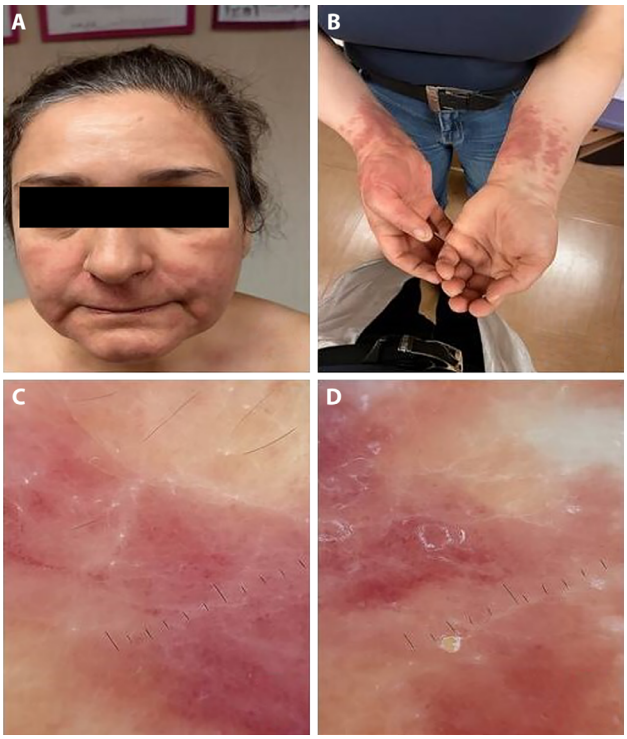

Figure 1. A. Clinical image of the face. This image shows sharply demarcated, erythematous and edematous plaques involving the facial skin, particularly the cheeks and forehead. The lesions present a characteristic photo distribution, consistent with phytophoto-dermatitis following sun exposure. No vesicle or crust was visible, which helped distinguish this eruption from photoallergic dermatitis. B. Clinical image of the hands. Well-defined erythematous plaques with early purpuric changes are seen on the dorsal hands, an area frequently exposed during gardening work. The bilateral but asymmetric distribution, along with petechiae and hyperpigmentation, supported the diagnosis of phototoxic reaction. The absence of excoriations further excluded pruritic eczematous processes. C. Dermoscopic image of a lesion on the hand. Dermoscopy revealed a red-orange background interspersed with clusters of hemorrhagic globules and dots, reflecting phototoxic microvascular damage. These elements were irregularly distributed without forming any specific vascular architecture, in contrast to immune-mediated dermatoses. The presence of these features strongly supports phytophotodermatitis. D. Dermoscopic image of a lesion on the face. A fine, whitish reticulated pattern is visible, overlying the inflamed area. This corresponds to alteration of the papillary dermis. In addition, focal areas of asymmetric fine desquamation were observed, more pronounced at the lesion borders. This peripheral scaling, along with the absence of yellow crusts or linear vessels, helped rule out eczematous dermatitis.

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