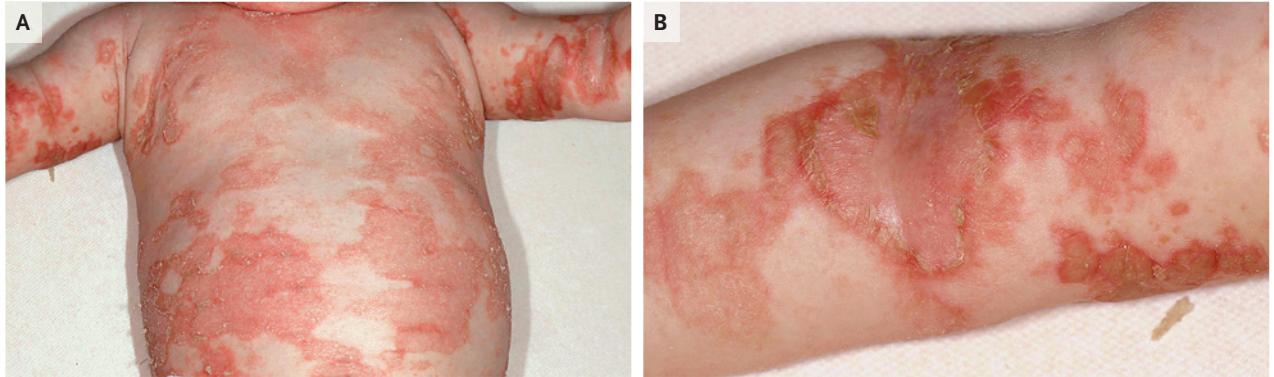


IMAGES IN CLINICAL MEDICINE

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Zinc Deficiency–Associated Dermatitis



A 4-MONTH-OLD BOY WHO HAD BEEN EXCLUSIVELY BREAST-FED WAS brought to the clinic with a 6-week history of a progressively worsening rash. Physical examination revealed widespread, well-defined, erythematous, erosive plaques on the abdomen (Panel A), arms (Panel B), legs, diaper area, face, and scalp. No other abnormal physical or developmental findings were observed. A skin biopsy was performed and revealed irregular orthokeratosis and parakeratosis, a reduced granular cell layer, and pallor of keratinocytes in the upper epidermal layers, findings that were suggestive of zinc deficiency. Laboratory studies showed a serum zinc level of 226 μg per liter (3.5 μmol per liter) (reference range, 600 to 1200 μg per liter [9.2 to 18.4 μmol per liter]), and a diagnosis of zinc deficiency–associated dermatitis was made. Zinc deficiency is readily treatable and important to consider since it may mimic treatment-refractory atopic dermatitis, impetigo, and other eczematous skin diseases. The underlying cause in this case was not clear, because the mother’s serum zinc levels were normal. Oral supplementation with zinc sulfate was initiated and resulted in almost complete resolution of the rash within 5 days. Oral zinc supplementation was continued, and during follow-up in the year after the initial presentation there was no recurrence of the rash.

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