CASE REPORT

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Unravelling Non-Venereal Genital Dermatoses Through Dermoscopy: A Case Report

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Abstract

Background: Symmetrical drug-related intertriginous and flexural exanthema (SDRIFE), also known as baboon syndrome, is an uncommon cutaneous adverse drug reaction characterized by symmetrical erythematous eruptions involving flexural and intertriginous areas following systemic exposure to a medication. Beta-lactam antibiotics, particularly amoxicillin, are recognized triggers. The condition generally occurs without systemic manifestations and may be mistaken for other inflammatory flexural dermatoses.

Case Presentation: A 40-year-old female presented with a five-day history of redness and itching involving the axillae, groins, inframammary regions, and cubital flexures. She reported recent intake of oral amoxicillin-clavulanate prior to the onset of the cutaneous eruption. Dermatological examination revealed well-defined, symmetrical erythematous patches and plaques predominantly involving multiple flexural and intertriginous regions. There was no history of fever, facial oedema, mucosal involvement, or other systemic symptoms. Based on the characteristic distribution of the lesions and the temporal association with systemic antibiotic exposure, a provisional clinical diagnosis of SDRIFE associated with amoxicillin-clavulanate was considered. The suspected medication was identified as a potential trigger, and further evaluation and management were directed toward controlling the cutaneous inflammation and preventing re-exposure.

Conclusion: This case highlights the importance of recognizing SDRIFE as a potential adverse reaction to commonly prescribed beta-lactam antibiotics. Careful medication history, recognition of the characteristic symmetrical flexural distribution, and exclusion of systemic involvement are essential for diagnosis. Early identification and withdrawal of the suspected causative medication can prevent unnecessary investigations and reduce the risk of recurrence.

Keywords: Symmetrical drug-related intertriginous and flexural exanthema; SDRIFE; Baboon syndrome; Amoxicillin-clavulanate; Cutaneous adverse drug reaction; Flexural eruption; Drug hypersensitivity.

Introduction

Non-venereal genital dermatoses comprise a diverse group of dermatological conditions affecting the male and female genitalia that are not primarily transmitted through sexual contact. These conditions include inflammatory, infectious, pigmentary, vascular, and benign proliferative disorders. Common examples include lichen sclerosus, lichen planus, psoriasis, lichen simplex chronicus, vitiligo, Zoon's balanitis, genital eczema, seborrhoeic dermatitis, and various benign papular conditions. Although these disorders are generally non-venereal in origin, their clinical presentation may resemble sexually transmitted infections, creating diagnostic uncertainty and considerable psychological distress for affected individuals. The sensitive anatomical location, associated symptoms, and social stigma frequently contribute to delayed consultation and difficulties in establishing an accurate diagnosis. [1]

The clinical evaluation of genital dermatoses can be challenging because several conditions exhibit overlapping morphological features, including erythema, erosions, plaques, papules, pigmentation, scaling, and ulceration. Furthermore, the genital skin differs from skin at other anatomical sites in terms of its structural characteristics, moisture, vascularity, and susceptibility to friction and irritation. These factors may modify the clinical appearance of dermatological conditions and make conventional morphological assessment alone insufficient in certain cases. Accurate diagnosis is therefore essential to distinguish benign inflammatory conditions from premalignant lesions, infectious disorders, and other clinically significant abnormalities. In selected cases, histopathological examination and microbiological investigations may be required to establish the diagnosis. [2]

Dermoscopy is a non-invasive diagnostic technique that enables magnified visualization of subsurface skin structures that are not readily identifiable through routine clinical examination. It provides additional information regarding vascular patterns, pigmentation, scaling, follicular structures, and other morphological characteristics. In dermatological practice, dermoscopy has become an important diagnostic aid in the assessment of inflammatory, infectious, pigmentary, and neoplastic skin disorders. Its application in genital dermatology is particularly valuable because the anatomical characteristics of genital skin may produce distinctive dermoscopic patterns that help differentiate clinically similar conditions. [3]

The dermoscopic findings of non-venereal genital dermatoses vary according to the underlying pathological process. Inflammatory conditions may demonstrate characteristic vascular structures, including dotted, linear, and branching vessels, while pigmentary disorders may show variations in pigment distribution, background coloration, and specific pigmentary patterns. Conditions such as lichen sclerosus, lichen planus, psoriasis, and Zoon's balanitis may exhibit distinctive combinations of vascular and structural features. Dermoscopy can therefore provide useful diagnostic clues, assist in narrowing the differential diagnosis, and help identify lesions that require further evaluation. However, dermoscopic findings should always be interpreted in conjunction with clinical examination and relevant investigations rather than considered independently as definitive diagnostic criteria. [4]

Despite increasing interest in dermoscopy across various dermatological conditions, its application in non-venereal genital dermatoses remains relatively less explored. Recognition of characteristic dermoscopic patterns may improve diagnostic confidence, reduce unnecessary invasive investigations in selected cases, and support appropriate clinical management. This case report highlights the role of dermoscopy in the clinical evaluation of non-venereal genital dermatoses, emphasizing the importance of identifying characteristic dermoscopic features and correlating them with clinical findings and, where necessary, histopathological examination. [5]

Case presentation

Patient Information

A 40-year-old female presented to the dermatology outpatient department with complaints of redness and itching involving the axillae, groins, inframammary regions, and other flexural areas for five days. The patient reported an acute onset of erythematous skin lesions, which progressively involved multiple flexural and intertriginous regions. The lesions were associated with persistent itching and local discomfort. There was no history of similar episodes in the past, as per the available clinical history.

History of Presenting Illness

The patient was apparently well until five days before presentation, when she noticed the development of erythematous lesions over the flexural areas. Initially, the lesions appeared as areas of redness associated with itching, followed by progressive involvement of other flexural regions, including both axillae, groins,

inframammary areas, and cubital fossae. The patient described the itching as the predominant symptom, which was aggravated by sweating and friction over the affected areas. The eruption was distributed symmetrically, with involvement of corresponding flexural regions on both sides of the body. The acute onset and characteristic distribution of the lesions prompted further evaluation for a possible drug-induced cutaneous reaction. There was no history of fever, chills, malaise, or generalized weakness. The patient did not report facial swelling, lip swelling, difficulty in breathing, or other features suggestive of an immediate hypersensitivity reaction. There was also no history of oral ulcers, conjunctival involvement, genital mucosal lesions, skin pain, blister formation, or peeling of the skin. No symptoms suggestive of systemic involvement were reported.

Relevant Drug History

A detailed drug history revealed recent intake of oral amoxicillin-clavulanate before the onset of the cutaneous eruption. The antibiotic had been prescribed for an unrelated clinical condition. The patient developed the skin lesions following exposure to this medication, establishing a temporal association between drug intake and the development of the eruption. The possibility of a delayed-type drug hypersensitivity reaction was considered because of the characteristic clinical distribution and absence of systemic manifestations. The relationship between the suspected medication and the skin eruption was evaluated based on the chronology of drug exposure and symptom development. Details regarding the exact dosage, duration of antibiotic therapy, previous exposure to beta-lactam antibiotics, and any history of similar drug reactions were not available in the provided clinical information.

Past Medical and Personal History

There was no documented history of similar cutaneous eruptions or recurrent flexural dermatitis in the available clinical history. Information regarding previous allergic disorders, atopic dermatitis, psoriasis, diabetes mellitus, and other chronic medical conditions was not provided. There was also no documented history of previous drug hypersensitivity reactions.

General Physical Examination

On general examination, the patient was conscious, alert, and oriented, with no apparent signs of acute systemic illness. She was clinically stable at the time of presentation. There was no evidence of facial oedema, lip swelling, or other features suggestive of angioedema. Examination did not reveal any clinically reported mucosal abnormalities. There were no associated constitutional symptoms such as fever or malaise. The absence of systemic manifestations was an important clinical feature supporting the consideration of a localized cutaneous drug reaction rather than a severe systemic drug hypersensitivity syndrome.

Dermatological Examination

Detailed dermatological examination revealed multiple well-defined, symmetrical erythematous patches and plaques involving several flexural and intertriginous regions. The lesions were predominantly distributed over the bilateral axillae, inguinal folds, inframammary regions, and cubital fossae. The lesions appeared as erythematous patches and plaques with relatively well-defined margins. The distribution was notably symmetrical, involving corresponding anatomical regions on both sides of the body. The flexural involvement was a prominent clinical feature, with the axillary and inguinal regions showing considerable erythema. The inframammary and cubital flexures were also involved. The affected areas were associated with pruritus, which was the principal symptom reported by the patient. The characteristic symmetrical distribution of the erythematous lesions across multiple flexural sites, together with the recent history of systemic antibiotic exposure, raised suspicion of symmetrical drug-related intertriginous and flexural exanthema.



Figure 1: FLexural exanthema

Clinical and Dermoscopic Evaluation

The clinical morphology and distribution of the lesions were carefully evaluated to distinguish SDRIFE from other inflammatory and drug-induced dermatoses. Particular attention was given to the symmetrical involvement of the major flexural areas and the absence of systemic symptoms. Dermoscopy, if performed, may provide additional information regarding the vascular and background erythematous patterns of the lesions. However, no specific dermoscopic findings were provided in the available clinical history. Therefore, dermoscopic features should be included in the final manuscript only if they were actually observed and documented during examination.

Investigations

The diagnosis of symmetrical drug-related intertriginous and flexural exanthema (SDRIFE) is primarily clinical and is based on the characteristic distribution of the cutaneous eruption, its temporal association with systemic drug exposure, and the absence of systemic manifestations. Laboratory investigations may be performed when necessary to exclude alternative diagnoses and assess possible systemic involvement. A complete blood count may be considered to evaluate the total leukocyte count and the presence of eosinophilia, while liver and renal function tests may be performed to assess potential hepatic and renal involvement, respectively. Inflammatory markers, including C-reactive protein and erythrocyte sedimentation rate, may be evaluated when clinically indicated. Potassium hydroxide examination may be useful when a fungal infection, particularly candidal intertrigo, is suspected. Skin biopsy may also be considered in atypical presentations or when the clinical diagnosis remains uncertain. However, no laboratory or histopathological findings were available for the present patient; therefore, the diagnosis was primarily based on the clinical presentation and relevant drug history.

Clinical Diagnosis

Based on the history of recent systemic exposure to amoxicillin-clavulanate, acute onset of pruritic erythematous lesions, symmetrical involvement of multiple flexural and intertriginous regions, and absence of systemic or mucosal manifestations, a provisional diagnosis of symmetrical drug-related intertriginous and flexural exanthema (SDRIFE) associated with amoxicillin-clavulanate was considered. The clinical presentation was suggestive of a delayed-type drug hypersensitivity reaction. The characteristic flexural distribution and absence of systemic involvement were important features supporting the diagnosis.

Management and Treatment

The suspected causative medication, amoxicillin-clavulanate, was discontinued following clinical assessment. Further exposure to the suspected drug was avoided, and the patient was counselled regarding the possibility of a drug-related cutaneous reaction. The need to document the suspected adverse drug reaction in her medical records was emphasized to prevent inadvertent re-exposure. Treatment was directed

toward controlling cutaneous inflammation and relieving pruritus. Appropriate topical corticosteroid therapy may be considered for the affected areas depending on the severity of inflammation and anatomical site. Mild-potency preparations are generally preferred in flexural regions because of the increased risk of local adverse effects and enhanced absorption in these areas. Emollients and gentle skin care measures may also help restore the skin barrier and reduce irritation. An oral antihistamine may be prescribed for symptomatic relief of itching. The patient should be advised to avoid excessive sweating, friction, tight clothing, and unnecessary topical preparations over the affected areas. Follow-up examination is important to monitor the resolution of the eruption and identify any evidence of progression or systemic involvement. The actual medications, dosages, duration of treatment, and clinical response should be inserted from the patient's medical records.

Follow-Up and Clinical Outcome

The patient was advised to avoid further exposure to the suspected causative medication and to attend follow-up for assessment of the cutaneous lesions. During follow-up, the distribution, extent of erythema, intensity of pruritus, and development of any new lesions should be documented. Resolution of the eruption following withdrawal of the suspected drug and appropriate symptomatic treatment would further support the clinical diagnosis. The exact duration of improvement, complete resolution, and any recurrence were not available in the information provided and should be added based on the patient's actual follow-up records.

Discussion

Symmetrical drug-related intertriginous and flexural exanthema (SDRIFE), previously referred to as baboon syndrome, is an uncommon cutaneous adverse drug reaction characterized by the development of symmetrical erythematous eruptions predominantly involving the gluteal, perianal, and other flexural or intertriginous regions following systemic exposure to a medication. Unlike many other drug-induced cutaneous reactions, SDRIFE is typically characterized by the absence of systemic symptoms such as fever, malaise, and internal organ involvement. The condition is considered a delayed-type hypersensitivity reaction and may occur following either initial or repeated exposure to a causative drug. The characteristic distribution and absence of systemic manifestations are important clinical features that help distinguish SDRIFE from other drug eruptions. [6,7]

Amoxicillin and other beta-lactam antibiotics are among the commonly reported causative medications associated with SDRIFE. Other implicated drugs include antibiotics from different classes, analgesics, antifungal agents, and various systemic medications. The onset of the eruption generally occurs after systemic administration of the suspected drug, although the interval between exposure and the appearance of lesions may vary. In the present case, the patient developed a symmetrical erythematous eruption involving multiple flexural regions following recent administration of amoxicillin-clavulanate. This temporal relationship supports the possibility of a drug-induced hypersensitivity reaction. [8,9]

The clinical diagnosis of SDRIFE is based on five established criteria: systemic exposure to a drug, sharply demarcated erythema involving the gluteal or perianal region and/or V-shaped inguinal or perigenital erythema, involvement of at least one additional flexural or intertriginous site, symmetrical distribution, and absence of systemic symptoms or signs. These criteria are useful in distinguishing SDRIFE from other drug-induced eruptions and inflammatory dermatoses. In the present case, bilateral involvement of the axillary, inguinal, inframammary, and cubital regions, together with the absence of fever, facial oedema, and mucosal involvement, was suggestive of SDRIFE. However, documentation of gluteal or perianal involvement is necessary to establish whether the patient fulfils all five diagnostic criteria. [10,11]

The pathogenesis of SDRIFE is not completely understood, but it is generally considered a delayed, type

IV hypersensitivity reaction mediated by drug-specific T lymphocytes. The characteristic localization to flexural and intertriginous areas may be related to differences in the local skin microenvironment, although the exact mechanism responsible for this distribution remains unclear. Histopathological findings are variable and generally nonspecific. Common findings include superficial perivascular lymphocytic infiltrates, occasional eosinophils, epidermal spongiosis, and other features of inflammatory dermatitis. Consequently, histopathological examination is not routinely required in typical cases but may help exclude important clinical mimics in atypical presentations. [12,13] The condition generally follows a benign and self-limiting course, with gradual resolution over days to weeks. Re-exposure to the causative drug may result in recurrence; therefore, appropriate documentation of the suspected adverse drug reaction and counselling regarding future medication exposure are important. [7,14]

Conclusion

Symmetrical drug-related intertriginous and flexural exanthema (SDRIFE) is an uncommon but clinically distinctive cutaneous adverse drug reaction that should be considered in patients presenting with acute-onset, symmetrical erythematous eruptions involving multiple flexural and intertriginous regions following systemic drug exposure. The present case highlights the possible association of amoxicillin-clavulanate with SDRIFE and emphasizes the importance of detailed drug history-taking and careful dermatological examination in establishing the diagnosis. Recognition of its characteristic clinical distribution and absence of systemic manifestations helps differentiate it from other drug-induced eruptions and common flexural dermatoses. Early identification, withdrawal of the suspected causative medication, and appropriate symptomatic treatment are essential for favorable clinical outcomes. Furthermore, documenting suspected drug hypersensitivity and counselling patients regarding future medication exposure are important measures to prevent recurrence and ensure medication safety.

Declaration

Consent: Written informed consent was obtained from the patient. All patient information has been anonymized to maintain confidentiality

Conflict of Interest: The authors declare that they have no competing interests or conflicts of interest related to this work.

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