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## Hand Contact Dermatitis Made a Patient Blind for the Second Time!

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Wood contact dermatitis is a rare condition, but it is frequently reported in occupational contexts, especially in association with tropical woods [1]. Sensitization in such cases is related to direct or airborne exposure to wood dust [1]. There have been only rare reports of sensitization to solid wood and finished wood products such as instruments, wooden jewelry, and knife handles [1].

We report the case of a 38-year-old woman, blind since the age of 15 years due to retinal detachment, who developed contact dermatitis after exposure to wood. In the previous 14 months, she had developed erythema on both hands, as well as severe lesions consisting of erythematous lichenified plaques alternating with vesicles, particularly affecting the tips of the fingers. The lesions resulted in dreadful itching and a progressive loss of sensitivity that prevented the patient from reading Braille. No other lesions were observed at any other skin sites. Symptoms were only partly controlled with local and systemic corticosteroid treatment, with incomplete remission of skin lesions. Allergic persistent moderate/severe rhinitis to *Dermatophagoides pteronyssinus* had been previously diagnosed. The patient underwent patch testing with the European baseline series (Chemotechnique Diagnosis, Vellinge, Sweden). Allergens were applied on the upper back using 8 mm Finn Chambers (Epitest, Oy, Finland). The readings were noted on days 2 and 4 according to International Contact Dermatitis Research Group criteria. All the results were negative.

A careful evaluation of the patient's routine revealed the use of wood in writing equipment (*Jugulans nigra*, *Fagus*

*sylvatica*), a walking stick (*Swietenia mahogany*), door handles (*Quercus robur*, *Pinus monticola*), a working desk (*Chlorophora excelsa*) and a piano used daily for teaching (*Swietenia mahogany*, *Gossweilerodendron balsamiferum*). We performed patch tests with natural dust from these woods (10% in petrolatum). The patches were left in place for 48 hours and readings recorded at 48 hours (1 hour after removal) and 72 hours. The results were positive for *G balsamiferum*, *F sylvatica*, and *Q robur* (++, strong reaction for all) at 48 hours, with persistence of lesions at 72 hours. The same tests carried out in 2 healthy individuals and 2 patients with nickel contact dermatitis were negative.

The exhaustive investigation of less common potential contact allergens was essential for the diagnosis of contact dermatitis to wood in our patient, with results showing sensitization to 1 exotic wood (*G balsamiferum*) and 2 nonexotic woods (*F sylvatica* and *Q robur*) through exposure to finished articles.

Contact dermatitis to exotic wood has been reported in the past [2,3], but we found no recent reports. Sensitization to *F sylvatica*, in contrast, has been rarely reported in the past, but there have been some recent cases described in occupational settings [4,5]. *Q robur* seems to be less likely to induce contact dermatitis, with only 1 report of 3 patients in the literature [6]. The negative results to allergens from the European baseline series used in the preparation of wood varnishes, resins, and preservatives corroborate exclusive sensitization to wood.

Complete avoidance of the objects made with the woods to which our patient was sensitized resulted in the remission of skin lesions. The specific diagnosis was essential in this particular case as it allowed us to propose specific measures to help the patient, who was blind, to recover her ability to read braille and therefore regain quality of life.

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