1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Danielle R. Marsh

DOB
03/14/1985

AGE/SEX
41 / Female

MRN / PATIENT ID
DRM-7730418

DATE OF SERVICE
10/08/2026

PROVIDER
Priya Natarajan

CREDENTIALS
MD, FAAD

VISIT TYPE
Dermatology Consultation — Rash Evaluation (new patient)

CARE SETTING
Outpatient — Dermatology Clinic

PRIMARY CARE PROVIDER, IF APPLICABLE
Marcus Bell, DO

REFERRING PROVIDER, IF APPLICABLE
Marcus Bell, DO (PCP)

INTERPRETER USED, IF APPLICABLE
Not required — English

CHAPERONE PRESENT, IF APPLICABLE
Not required for hand exam

CC CHIEF COMPLAINT

2 PRIMARY DERMATOLOGY CONCERN

"My hands have been cracked and bleeding for eight months and it gets worse every time I work a run of shifts. Steroid cream from my doctor stopped working."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a PRESENTING CONCERN

Reason for Dermatology Evaluation:

Initial rash evaluation for chronic bilateral hand dermatitis refractory to primary-care management; referred for patch-testing candidacy and occupational guidance.

History of Present Illness:

Onset ~8 months ago (Feb 2026), about 6 weeks after her hospital switched to a new nitrile glove supplier and a fragrance-containing alcohol foam sanitizer. Began as dryness and stinging over the dorsal fingers, progressed to fissuring of the fingertips and palms with weeping vesicles on the sides of the fingers. Flares within 48–72 h of a 3-shift run (12 h each, ~60–80 hand washes/shift); improves ~50% after 4 days off but never clears. Two prior courses of triamcinolone 0.1% ointment gave partial relief for 1–2 weeks. Concerned about being moved off bedside duty.

Skin Lesion History:

No discrete lesions of concern. Reports one fissure on the right thumb pad that has bled intermittently for 3 weeks with honey-colored crust over the last 5 days.

Rash History:

Bilateral, roughly symmetric; dorsal fingers, palms, and lateral digits; spread to the volar wrists 2 months ago (glove-cuff line). Itching, burning, small clear blisters, scaling, and painful cracks. No fever. Forearms, face, and feet uninvolved. Flares track with work stretches; partial remission on vacation in July (10 days).

Pruritus / Pain Symptoms:

Itch 8/10, worst evenings after shifts; wakes 2–3 nights/week scratching. Fissure pain 6/10 with sanitizer application and gripping. Cetirizine 10 mg nightly gives minimal benefit.

3b CONDITION-SPECIFIC HISTORY

Acne / Rosacea Symptoms, if applicable:

Not applicable — denies acne or facial redness.

Eczema / Atopic Dermatitis History, if applicable:

Childhood flexural eczema, resolved by age 12. Mild intermittent asthma (albuterol PRN ~2×/month); seasonal allergic rhinitis. Moisturizes with a fragranced lotion 1–2×/day. No prior eczema herpeticum. Mother with eczema.

Psoriasis History, if applicable:

No psoriasis history; no scalp, elbow, knee, or genital plaques; no joint stiffness. Father has plaque psoriasis — considered in differential.

Hair and Scalp Symptoms:

Denies hair loss or scalp scaling. Uses a fragrance-free shampoo; hair dye every 8 weeks (PPD-containing box dye) — noted as possible allergen.

Nail Symptoms:

New transverse ridging of several fingernails and redness of proximal nail folds for ~3 months. No pitting, lifting, or drainage.

Mucosal / Genital Skin Symptoms, if applicable:

Not applicable — denies oral or genital lesions.

3c EXPOSURES & RISK

Sun Exposure and Skin Cancer Risk:

Fitzpatrick III. ~3 blistering sunburns in adolescence; no tanning beds; daily SPF 30 facial moisturizer. No personal or family skin cancer. No immunosuppression.

Medication and Product Exposure History:

Meds: levonorgestrel IUD, cetirizine 10 mg, albuterol PRN, triamcinolone 0.1% ointment (last used 9 days ago). Occupational: new nitrile gloves (thiuram/carbamate accelerators per supplier sheet), alcohol foam sanitizer with fragrance and benzyl alcohol, chlorhexidine 2% scrubs, adhesive tape. Home: fragranced dish soap, scented lotion, PPD hair dye.

Infectious Exposure History:

Works with MRSA-colonized patients; no known personal MRSA. One cat (no ringworm in household). No travel. No household contacts with rash.

Autoimmune / Systemic Symptoms:

Denies fever, weight loss, arthralgia, photosensitivity, Raynaud, or sicca. Fatigue attributed to night shifts.

3d TREATMENT & BACKGROUND

Treatment History and Response:

Triamcinolone 0.1% ointment BID ×2 courses (2 wk each) — partial response, rapid relapse. Hydrocortisone 1% OTC — no benefit. Petrolatum at night inconsistently. No systemic steroids, phototherapy, or antibiotics. Barrier: cannot apply ointment during shifts.

Past Dermatologic History:

Childhood atopic dermatitis. Reaction to nickel earrings in her 20s (itchy earlobes). No skin cancers, procedures, or keloids.

Family History:

Mother — eczema, asthma. Father — plaque psoriasis. Sister — Hashimoto thyroiditis. No melanoma.

Social / Occupational History:

Medical ICU RN, 3×12 h shifts/week; heavy wet work and continuous glove use. Gardens on weekends without gloves. Never smoker; alcohol 2–3 drinks/week. Married, two children (hand-washes dishes nightly). Insurance through employer.

Pertinent Negatives:

Denies fever, spreading redness up the forearm, lymphangitic streaking, lip/tongue swelling, urticaria with glove use, mucosal involvement, or skin sloughing. Not immunosuppressed.

ROS DERMATOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Rash, itching, burning, pain, swelling, drainage, scaling, crusting, blistering, or ulceration
Positive — itching, burning, scaling, vesicles, fissures; crusting at right thumb fissure.

New, changing, bleeding, painful, or non-healing skin lesion
Positive — bleeding right thumb fissure ×3 wk; no pigmented or growing lesion.

Acne, rosacea flares, scarring, hyperpigmentation, or treatment irritation
Negative.

Hair loss, scalp scaling, scalp pain, nail changes, or mucosal lesions
Positive — nail ridging, periungual redness. Negative for hair, scalp, or mucosal findings.

Fever, fatigue, weight loss, night sweats, joint pain, photosensitivity, oral ulcers, or systemic symptoms
Negative except shift-related fatigue.

Medication reaction symptoms, hives, swelling, respiratory symptoms, or mucosal involvement
Negative — no contact urticaria, wheeze, or angioedema with glove use.

Sunburns, tanning exposure, skin cancer history, or immunosuppression-related concerns
Remote adolescent sunburns only; otherwise negative.

Psychosocial distress, sleep disruption, pain, or functional impact related to skin disease
Positive — sleep disruption 2–3 nights/wk, anxiety about job role, embarrassment handing medications to patients.

O OBJECTIVE

5 OBSERVED FINDINGS

5a VITALS, IF OBTAINED

TEMPERATURE	BLOOD PRESSURE	HEART RATE
98.4 °F	**118/74**	**72**

RESPIRATORY RATE	OXYGEN SATURATION	HEIGHT
14	99% RA	5′6″
WEIGHT	**BMI**	**PAIN SCORE, IF APPLICABLE**
148 lb	23.9	6/10 (fissures)

5b EXAMINATION

General Appearance:

Alert, well-appearing, mildly uncomfortable when flexing fingers; actively rubbing palms during interview. Fully participates in care.

Skin Examination:

Bilateral hands: ill-defined erythematous, lichenified plaques with fine scale over dorsal proximal fingers and knuckles; deep-seated 1–2 mm vesicles along lateral digits (dyshidrotic pattern); multiple linear fissures on fingertips and palmar creases. Sharp proximal border at volar wrists bilaterally corresponding to glove cuff. Right thumb pad: 8 mm fissure with honey-colored crust and surrounding 1 cm erythema; no fluctuance, no lymphangitic streaking. Forearms, antecubital fossae, face, eyelids, and feet clear.

Lesion-Specific Examination:

Right thumb fissure 8 × 2 mm, tender, crusted, scant serous drainage. Baseline photographs of both hands (dorsal/palmar) taken for comparison.

Full-Body Skin Examination, if performed:

Not performed — focused exam of hands, forearms, face, scalp, and feet to evaluate distribution. Full-body exam offered at a future visit.

Scalp / Hair:

Normal density; no scale, erythema, or scarring along hairline or retroauricular skin.

Nails:

Transverse (Beau-like) ridging of R 2nd–4th and L 2nd–3rd fingernails; absent cuticles with mild periungual erythema; no pitting, onycholysis, or subungual debris.

Mucosa, if examined:

Oral mucosa and lips normal.

Lymph Nodes, if relevant:

No epitrochlear or axillary lymphadenopathy bilaterally.

Musculoskeletal, if relevant:

No joint swelling, dactylitis, or DIP tenderness; full range of motion, limited only by fissure pain.

MD DERMATOLOGIC MORPHOLOGY / DISTRIBUTION ASSESSMENT

6 MORPHOLOGY & PATTERN

PRIMARY LESION TYPE	SECONDARY SKIN CHANGES
Erythematous plaques; deep-seated vesicles	**Lichenification, scale, fissures, crust**
DISTRIBUTION AND SYMMETRY	**BODY SURFACE AREA AFFECTED WHEN RELEVANT**
Bilateral hands, dorsal > palmar; cuff-line border at wrists	**~3% BSA**

SEVERITY GRADING WHEN APPLICABLE

Hand Eczema IGA 3 (moderate-severe)

PRESENCE OF INFECTION, EXCORIATION, LICHENIFICATION, SCARRING, PIGMENT CHANGE, OR ULCERATION

Impetiginized right thumb fissure; lichenification; excoriations

DERMOSCOPIC FINDINGS WHEN PERFORMED

Not performed

COMPARISON WITH PRIOR PHOTOGRAPHS OR MEASUREMENTS

Baseline photographs obtained today

FUNCTIONAL OR COSMETIC IMPACT

Pain with gripping and sanitizer use; sleep disruption; job-role anxiety

PR PROCEDURES PERFORMED, IF APPLICABLE

7 IN-OFFICE PROCEDURES

1) KOH prep — indication: exclude tinea manuum given vesicular, partly asymmetric scale. Verbal consent. Scale scraped from L palm and R 3rd finger with #15 blade onto slide. In-office read: negative for hyphae. 2) Skin culture collection — indication: crusted, tender R thumb fissure. Verbal consent. Bacterial swab of fissure base sent for culture and sensitivity. Tolerated well, no complications. Petrolatum and nonstick dressing applied. Results to be called in 48–72 h.

ST SCREENING / ASSESSMENT TOOLS

8 SCORES & INTERPRETATION

BSA ~3%. Hand Eczema IGA 3/4 (moderate-severe). DLQI 14 — very large effect on quality of life (work and sleep domains highest). Pruritus NRS 8/10; fissure pain 6/10. No prior scores for comparison; establishes baseline. PHQ-2 negative. Adherence: good off-shift, poor on-shift due to ointment impracticality.

L LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED & ORDERED

Pathology:

None — biopsy not indicated at this time; reserve for nonresponse to patch-test-guided avoidance.

Microbiology:

KOH prep negative (in office). Bacterial culture R thumb fissure — pending.

Laboratory Testing:

PCP labs 08/2026 reviewed: CBC and CMP normal, TSH 1.9. No systemic therapy planned yet.

Allergy / Contact Dermatitis Testing:

Expanded patch testing ordered (North American baseline series + rubber accelerator and preservative/fragrance supplements + her own glove, sanitizer, and lotion). Suspected: thiuram/carbamate mix, fragrance mix, benzyl alcohol, PPD, nickel.

Imaging:

Not indicated.

Prior Records Reviewed:

PCP notes 03/2026 and 06/2026; employee-health glove-exposure report; glove manufacturer safety data sheet (lists zinc dithiocarbamate and thiuram accelerators).

A ASSESSMENT

10 DERMATOLOGIC CLINICAL INTERPRETATION

1) Chronic hand eczema, moderate-severe (IGA 3, DLQI 14), occupational — mixed irritant contact dermatitis (wet work, alcohol sanitizer) with suspected allergic contact dermatitis; temporal link to new accelerator-containing gloves and fragranced sanitizer, plus a sharp glove-cuff border, strongly suggests a rubber-accelerator or fragrance allergen. Atopic diathesis (childhood AD, asthma, rhinitis) lowers her irritant threshold. 2) Secondary impetiginization of R thumb fissure — localized, no cellulitis or systemic signs; culture pending. 3) Differential: hand psoriasis (family history; no nail pitting or other plaques — less likely), tinea manuum (KOH negative), dyshidrotic eczema as a reaction pattern. No features of malignancy or severe drug eruption. Mid-potency steroid inadequate and impractical on shift. Needs potent topical therapy, barrier and glove changes, patch testing, and occupational documentation.

P PLAN

11 DERMATOLOGY MANAGEMENT BY PROBLEM

Topical treatment plan

Clobetasol 0.05% ointment to affected hand plaques BID ×2 weeks, then weekends only ×4 weeks (dispense 60 g). Under cotton gloves at night for the first week. Then tacrolimus 0.1% ointment BID weekdays as steroid-sparing maintenance. Fragrance-free ceramide cream after every hand wash at work and petrolatum at bedtime. Counseled on potent-steroid atrophy risk; avoid face and folds.

Systemic treatment plan

None today. If not controlled after patch-test-guided avoidance and 8 weeks of potent topicals, discuss alitretinoin (via compounding/off-label), oral JAK inhibitor, or dupilumab given atopic background; would require baseline labs and contraception review (IUD in place).

Procedure plan

Culture follow-up as above. Fissure care: petrolatum and nonstick dressing daily; cyanoacrylate liquid bandage for fingertip fissures on shift.

Skin cancer prevention plan

Continue daily SPF 30+; full skin exam offered at follow-up given adolescent sunburns. ABCDE handout provided.

Rash or dermatitis plan

Patch testing (scheduled 10/19–10/23). Interim: switch to accelerator-free nitrile gloves (employee health letter provided) with cotton liners; use fragrance-free sanitizer; soap-free cleanser at home; vinyl gloves over cotton for dishes and gardening. Stop fragranced lotion. Hold hair dye until patch results.

Acne/rosacea plan

Not applicable.

Psoriasis/eczema plan

Severity-based topical step-up and step-down as above; written hand-eczema action plan provided. Will re-screen for psoriasis features if patch testing is negative.

Hair/nail plan

Nail ridging expected to grow out with control of periungual dermatitis; avoid cuticle trimming.

Infection plan

Mupirocin 2% ointment to R thumb fissure TID ×7 days; adjust per culture. No oral antibiotic given localized infection. Return for spreading redness, streaking, or fever.

Medication monitoring plan

No labs for topical therapy. Pre-systemic labs deferred until needed.

Referral and care coordination plan

Letter to employee health/occupational medicine: accelerator-free gloves, fragrance-free sanitizer, and temporary modified-duty consideration if fissures are open. Results copied to PCP.

Patient education

Explained irritant versus allergic mechanisms, that hand eczema clears slowly over 6–12 weeks, fingertip-unit dosing, and patch-test preparation (no clobetasol on the back; no antihistamine changes needed). Teach-back confirmed.

F FOLLOW-UP

12 REASSESSMENT PLAN

Culture result call in 48–72 h. Patch testing 10/19 (application), 10/21 and 10/23 (readings). Return 4 weeks after the final read to review results, give allergen-avoidance counseling, check IGA/DLQI, and decide on step-down. Return sooner for spreading infection, fever, or widespread rash.

TB TIME DOCUMENTATION & BILLING

13 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
52 minutes

COUNSELING / EDUCATION TIME
20 minutes

PROCEDURE TIME, IF APPLICABLE
8 minutes (KOH, culture)

SKIN CANCER COUNSELING TIME, IF APPLICABLE
2 minutes

MEDICATION MONITORING TIME, IF APPLICABLE
—

CARE COORDINATION TIME
8 minutes (employee health letter)

RECORDS REVIEW TIME, IF APPLICABLE
6 minutes

13a BILLING CONSIDERATIONS — E/M / DERMATOLOGY CODING

E/M LEVEL
99204

BIOPSY CODE(S), IF APPLICABLE
—

DESTRUCTION / CRYOTHERAPY CODE(S), IF APPLICABLE
—

INJECTION CODE(S), IF APPLICABLE

—

EXCISION / REPAIR CODE(S), IF APPLICABLE

—

PATHOLOGY / TEST INTERPRETATION CODE(S), IF APPLICABLE

87220 (KOH); 87070 (culture, lab)

BASIS FOR BILLING

Medical Decision Making (moderate) + test interpretation

ICD-10 DIAGNOSIS CODES

L30.9 — Dermatitis, unspecified (chronic hand eczema); L24.9 — Irritant contact dermatitis, unspecified cause

[SECONDARY DIAGNOSIS / LESION / SYMPTOM CODE(S), IF APPLICABLE]

L23.9 — Allergic contact dermatitis, unspecified cause (suspected); L01.00 — Impetigo, unspecified; Z57.8 — Occupational exposure to other risk factors

SO SIGNATURE

14 PROVIDER SIGN-OFF

PROVIDER NAME

Priya Natarajan

CREDENTIALS

MD, FAAD

SPECIALTY

Dermatology

DATE

10/08/2026

TIME

10:45