A 20-year-old woman presented in mid-winter with a mildly painful, swollen, and discolored left toe of a week’s duration. She had also noted several small pruritic lesions on the toes of both feet. Similar lesions had intermittently appeared and resolved over the previous few winter months. She denied fevers, chills, joint pain, fatigue, changes in menstruation, or other systemic symptoms.

There was no history of trauma to her feet or excessive cold exposure. The patient’s history was notable only for intermittent tinea versicolor. She used oral contraceptive pills but was not taking any other daily medications or supplements. She was allergic to erythromycin. She did not smoke cigarettes, drank alcohol occasionally, and denied any history of intravenous or other drug use. There was no family history of dermatologic or autoimmune disorders.

The patient’s vital signs were all within normal limits; her BMI was 21 kg/m². No conjunctival or oral mucosal abnormalities were noted. Cardiac examination found no murmurs. Respiratory and abdominal examinations were unremarkable. Dorsalis pedis and posterior tibial pulses were 2+ and capillary refill was normal. The feet were mildly cool to the touch.

The patient was seen 2 times, 10 days apart. At the first visit, the left fourth toe was mildly swollen and was slightly purple. There were
small violaceous macules on the ends of several toes. Ten days later, most of the swelling and purplish discoloration of the affected toe had resolved, but there was still a faintly violaceous plaque on the top of the toe. Purple macules were noted on the tip of the left third toe and on the medial aspect of the right third toe, near the nailbed (Figures). At this visit she was wearing brown leather boots with cotton socks. The complete blood count was normal. Erythrocyte sedimentation rate was 3 mm/hr. Assays were negative for antinuclear antibodies and rheumatoid factor.

What do you think explains these symptoms?
To find the diagnosis for these purple toes, click here.

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