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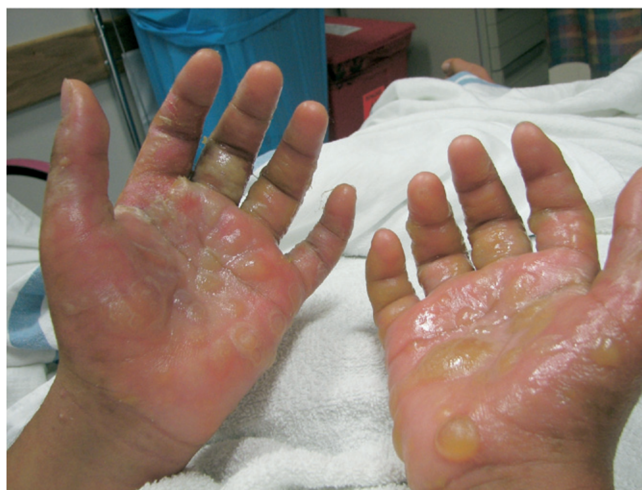

Figure. Rash on hands. Used with permission of Manoj K. Mittal, MD, MRCP(UK), Division of Emergency Medicine, The Children's Hospital of Philadelphia, Philadelphia, PA, and the Department of Pediatrics, University of Pennsylvania School of Medicine, Philadelphia, PA.

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An 11-year-old boy presented to the emergency department with a bullous eruption on both hands and feet. The itchy rash started on the left index finger as blisters about 1 month earlier, gradually progressing to involve both hands and then about 10 days earlier spread to the feet. It hurt to walk, but otherwise the rash was not painful. There was no history of fever or exposure to plants or to any kind of toxins. The patient had been treated by multiple providers throughout the last month and had used over-the-counter soothing creams, antifungal creams, and oral acyclovir, without benefit. There was history of mild intermittent asthma and allergic rhinitis. On examination, his vital signs were normal. His body mass index was on the 85th percentile. His hands and feet were swollen and erythematous, with crusting and weeping, and had multiple blisters and bullae filled with clear-to straw-colored fluid (Figure). Some of the bullae had ruptured, leaving denuded areas of skin. There was full range of motion at all finger and toe joints and no neurovascular involvement. The remainder of the examination was normal.

For the diagnosis and teaching points, see page 21.
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ple have bad outcomes in the US all the time, and it's because they're waiting, and it's not the person who has stellar insurance. It's the person who has no insurance and has no primary care."

Murphy agreed that "if I need an MRI or CT, I'm not going to have a problem getting an MRI or CT" in Canada.

In the US, however, "the indications for an emergency MRI are driven by a wallet biopsy, not by the medical necessity by and large. There is so much stuff that we did in labs in the US that if they were insured they got it, if they weren't they didn't. In Canada everybody's insured."

CREATING QUEUES

He added, "the way we control access in the US is by the ability to pay. The way we control access in Canada, and costs, is by creating queues, which is a different approach to the same problem."

As to the single-payer system, all the doctors agreed that Canada is not going to change. Some limited fee-for-service private clinics are being provided, and some firms are brokering for treatment in the US, but as to universal access to health care, Dr. Drummond said, "It's a core value, it's in their *soul*."

So, should the US go to such a system? Murphy said the US should do something to provide primary care to the uninsured and catastrophic health care coverage for all. But beyond that, he said, the US could not afford single-payer—"not because you don't have the money, you have lots of money, but because you would put millions of people out of work that are in the insurance business."

He said payment hassles—for both doctor and patients—that are a routine annoyance in the US are virtually nonexistent in Canada. In 2 comparable-sized clinics he has practiced at in Canada and the US, the former had "one-point-five billing clerks," the latter had 40.

Dr. Diner said he does not support universal coverage in the US because it would simply mean "that insurance companies are going to get richer and richer than they already are." But he does support single-payer, because "around 22% of health care expenses come from the insurance companies, and if you compared that to the Ontario government, it's 1% for administration. That's a single-payer system."

Dr. Drummond pointed to a personal example, when he and his wife had triplets 12 weeks premature and they had to spend 4 months in neonatal intensive care. "It cost me not one thin dime."

Well, in cash maybe, but how about taxes? "I pay a lot of 'em, but nobody gets denied care on the basis of an inability to pay."

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DIAGNOSIS:

Dyshidrotic eczema. Dyshidrotic eczema, also known as pompholyx, is a chronic relapsing form of vesiculobullous dermatitis involving palms and soles. It is equally common in male and female individuals. The exact cause is unknown. Various factors, including atopy, atopic dermatitis, contact dermatitis, ingested heavy metals, fungal or dermatophyte infection, hyperhidrosis, smoking, and intravenous immunoglobulin, have been implicated in its causation or aggravation.[1,2] Bacterial infection, when it occurs, is considered to be a result of itching and is a complication rather than the cause. The differential diagnosis of dyshidrotic eczema includes pustular psoriasis, bullous impetigo, dyshidrosiform pemphigoid, epidermolysis bullosa, hand-foot-mouth disease, herpes infection, and acrodermatitis enteropathica. Treatment is difficult. It includes local or systemic steroids, plus antimicrobials as needed for secondary infection. Topical tacrolimus or pimecrolimus may also be used instead of local steroids.[3,4] Moisturizers and antihistaminic agents are used to control itching.

Our patient was also treated by the dermatology team. Bacterial cultures from the involved area grew methicillin-resistant *Staphylococcus aureus*. Fungal and dermatophyte cultures were negative, as were the polymerase chain reaction tests for herpes simplex and varicella zoster viruses. The patient was discharged home and received a 2-week tapering course of prednisolone, clindamycin, and wet soaks with aluminium acetate. This resulted in significant improvement, but cessation of treatment led to a relapse. Prednisolone was continued for another 2 weeks, along with local application of a low-potency steroid cream.

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