Case 15
A 62 year-old Thai woman from Ratchaburi

Chief complaint: Asymptomatic erythematous papules on left cheek for 1 month

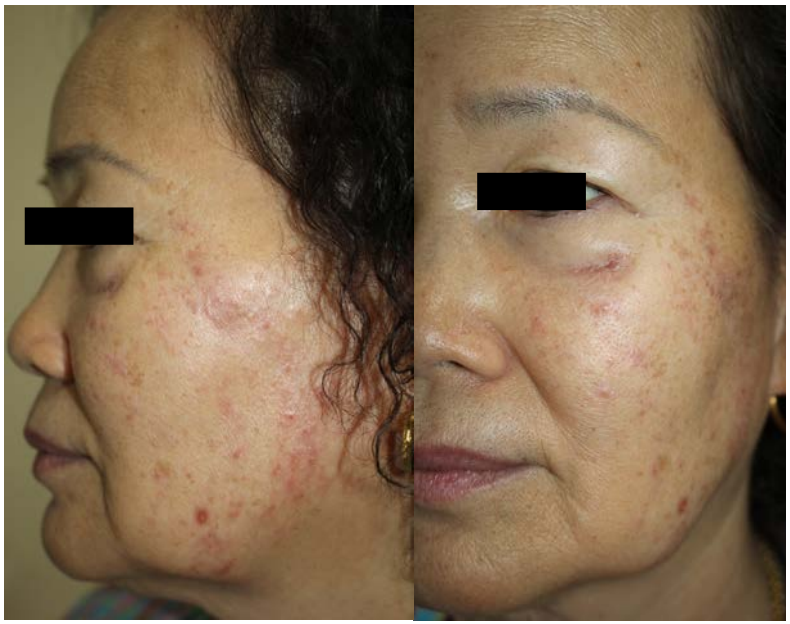

Fig. 15.1

Present illness:
1 month PTA the patient initially developed multiple erythematous papules on left cheek.

A topical chloramphenicol ointment and oral medications were prescribed from a clinic but were ineffective.

The patient went to the Dermatology clinic and a topical 2% hydrocortisone ointment was started for 2 months without improvement.

She denied history of itch, weight loss, fever, photosensitivity, telangiectasia, flushing or aggravation with alcohol or spicy foods.

Underlying disease: Rheumatoid arthritis (diagnosed since 2001)

Current medication:
- Methotrexate 7.5 mg/wk
- Leflunomide 20 mg/day
- Hydroxychloroquine 200 mg/day
- Folic acid 5 mg/day

Drug allergy: Pipemidic acid (facial edema)

Family history: No family history of skin disease

Dermatologic examination: (Fig. 15.1)
- Multiple discrete asymptomatic erythematous papules on left cheek

Physical examination:
- No joint swelling/joint pain
- Other systemic examination revealed no abnormality

Diascopy: Apple–jelly appearance

Investigations:
- KOH: negative

Histopathology: (S16-027657A, skin, left face) (Fig. 15.2)

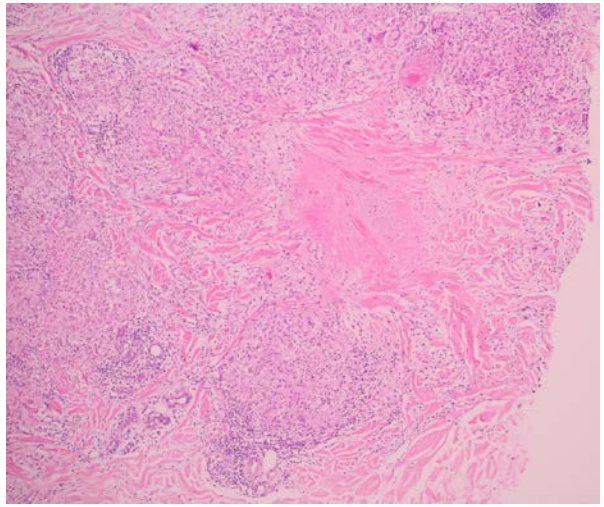

Fig. 15.2

- Nodular inflammatory cells infiltrate composed of lymphocytes, epithelioid histiocytes giving the feature of tuberculoid granuloma in the dermis
- Confluent tuberculoid granuloma with central necrosis

Diagnosis: Lupus miliaris disseminatus faciei

Treatment

- Doxycycline (100) 1 tab twice a day
- Metronidazole gel apply lesion twice a day

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Discussion:

Lupus miliaris disseminatus faciei (LMDF) is a rare chronic, granulomatous skin disease which is characterized by monomorphic erythematous-brown or yellowish-brown dome shaped papules and nodules predominantly localized on central to lateral face.[1]The lesions are ranging from 1-3 mm. in diameter predominantly on the upper eyelids and also observed on the lower eyelids, cheek, nasolabial fold, neck and chin .[2.3] Extrafacial manifestations include axillae, shoulders, arms, hands, groins and legs.[2] The lesions usually resolving with pitting scars.[4] A diascopy may reveal an apple jelly color appearance.[5]

The etiology of LMDF is still not well understood. LMDF is predominantly found in young adults and equal in both gender.[3] Originally, LMDF was considered to be a variant of lupus vulgaris or a tuberculid due to the histopathological presented with granulomatous–type inflammation and caseous necrosis.[2,3,6] Nevertheless, there was no evidence supporting a link between LMDF and tuberculosis. Some dermatologist considered LMDF to be a variation of granulomatous rosacea due to the lesions on centro-lateral face and histopathology. Even though, there was not any features of granulomatous rosacea such as flushing/flaring with alcohol, sunlight exposure or spicy foods. Furthermore, granulomatous rosacea always resolve without scarring formation.[4] In 2000, there was a proposal to change the name from LMDF to facial idiopathic granulomas with regressive evolution (FIGURE) or acne agminata but they were not widely use.[6]

The histopathologic characteristic of LMDF is an epithelioid cell granuloma with central necrosis.

Our patient is a typical case of LMDF and a diagnosis can be made based on clinical appearance (erythematous papule on the face) and microscopic pathology (epithelioid cell granuloma with central necrosis) which can help rule out the other similar conditions.

LMDF is a self–limiting disease which may persist for months or many years without treatment.[7] Regardless, treatment at the early stage can decrease pitting scar formation.[3]

There are various approaches to treat LMDF. Standard treatment is minocycline but the result is inconsistent.[8] Moreover, glucocorticoids, dapsone, tetracycline, doxycycline have also been reported as an effective treatment.[5] In recent years, the combination between oral metronidazole or dapsone and topical tacrolimus ointment has been reported as successful treatments.

As minocycline is not available in Thailand, we prescribed a combination of doxycycline and topical metronidazole gel instead. The lesions were decreased in number after 3 months and some of them resolved with post inflammatory hyperpigmentation.

Reference:

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