To the Editor:

A case of cutaneous sarcoidosis

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Introduction

Sarcoidosis is a systemic granulomatous disease of undermined etiology and pathogenesis, that involves the skin and many of internal organs with a persistent course interrupted by remissions and relapses.

Cutaneous involvement in sarcoidosis may be specific which reveals granulomas on biopsy or non specific which is mainly reactive. Quite varied cutaneous manifestations of sarcoidosis include papules, nodules, plaques, scar sarcoidosis, erythroderma, ulcerations, verrucose lesions, icthyosiform lesions, hypomelanotic lesions and alopecia.

Case report

We report a 50 years old female who presented to the dermatology clinic with clinical features compatible with cutaneous sarcoidosis in January 2002. She initially presented with multiple plaque lesions symmetrically affecting both upper limbs; skin biopsy at that time was suggestive of tuberculoid leprosy and patient was treated with anti leprosy paucibasillary therapy for 6 months. In spite of anti leprosy treatment she continued to develop new lesions and skin biopsy when repeated too showed granulomatous lesions possible with the diagnosis of leprosy or lupus vulgaris. As clinical features were favouring leprosy, multibacillary (MB) treatment was initiated in August 2002.

Even after one year of MB therapy her skin lesions showed little improvement. Thereafter her skin lesions became progressive. She developed new plaques lesions appearing symmetrically at the back, upper chest (fig 1) and upper limbs (fig 2). She also developed diffuse scarring alopecia and icthosiform lesions of both legs. At this time a clinical diagnosis of sarcoidosis was made and was confirmed by skin biopsy.

Her basic investigations including full blood count, fasting blood sugar, blood urea and serum electrolytes were within normal limits. Serum calcium level which is 2-1 mg/dl was also normal.

Her chest X-ray did not show any features of sarcoidosis and lung function tests were within normal limits. Examination of her eyes did not show any features of sarcoidosis. ECG and ecocardiogram was normal.

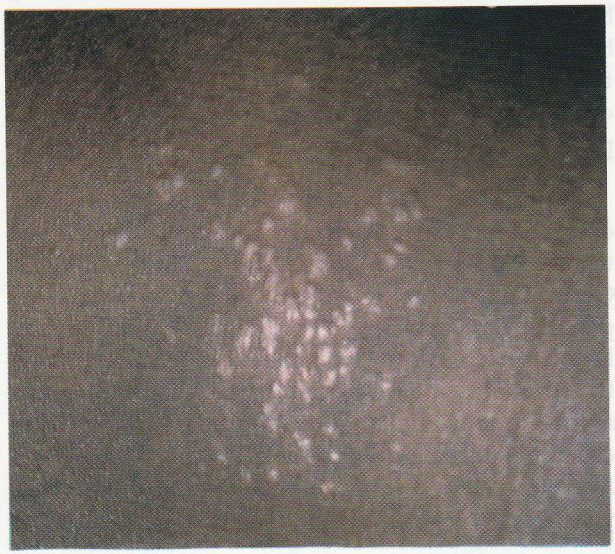

Figure 1.

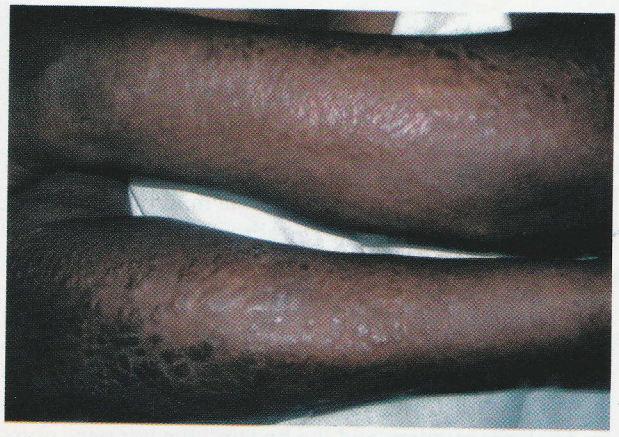

Figure 2.

At this stage we commenced her on oral prednisolone at a dose of 0.5 mg/kg and there was a marked improvement in her skin lesion, after one month of treatment.

Conclusion

Presence of cutaneous lesions compatible with scarcoidosis and exclusion of other possible of granulomatous skin disorders, supportive histology, dramatic response to steroid and exclusion of systemic involvement confirmed the diagnosis of cutaneous scarcoidosis.

References

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