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Akneiform Eruptions on the Body

Rukiye Yasak Güner[1], Ahmet Kozan[2], Sibel Berksoy Hayta[3], Ömer Fahrettin Göze[4]

[1] Sivas Cumhuriyet University Faculty of Medicine Department of Dermatology, Sivas, Turkey
[2] Amasya Training and Research Hospital, Department of Dermatology, Amasya, Turkey
[3] Acibadem Health Group, Istanbul, Turkey
[4] Sivas Cumhuriyet University Faculty of Medicine Department of Pathology, Sivas, Turkey

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Abstract **Case Report**

Acneiform eruptions are always confusing. Sometimes physician can have trouble diagnosing. Lupus miliyaris disseminatus fascia (LMDF) is also called acne agminata, Lewandowsky's rosacea-like tuberculid, micropapular tuberculid, lupoid rosacea, acne and facial idiopathic granulomas. MDF lesions are mostly presented on the face and extrafacial involvement is rare. We here present a case of patient with late diagnosed Lupus miliyaris disseminatus fascia. He had also extrafacial involvement such as regions were neck, trunk, and arms.

INTRODUCTION

Lupus miliyaris disseminatus fascia (LMDF) is also called acne agminata, Lewandowsky's rosacea-like tuberculid, micropapular tuberculid, lupoid rosacea, acne and facial idiopathic granulomas.[1] The etiology of LMDF is still not clear and primarly affects young adults. LMDF is characterized by an asymptomatic papular eruption mainly involving the central face. Red-to-yellow or yellow-brown papules of the central face, particularly on and around the eyelids. [2]

CASE REPORT

A male patient aged 26 years presented with itchy acneiform rashes for two years was admitted to our outpatient clinic. For these lesions, he had previously received systemic corticotherapy, isotretinoin, systemic and topical antibiotic treatments. There was no another disease in his past history. On dermatological examination, pruritic follicular papules and pustules located primarily on the upper trunk, neck , upper arms and forehead (Figure 1).

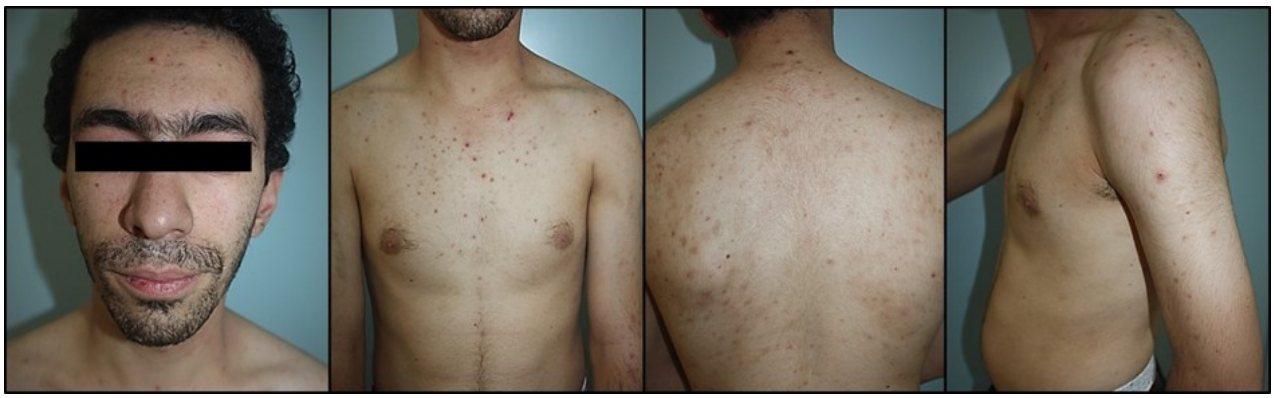

Figure 1: Erythematous papulopustular lesions on the anterior and posterior body, nape, and forehead

We asked some questions to rule out acneiform drug reaction, pityrosporum folliculitis, papular sarcoidosis, LMDF, secondary syphilis and acneiform presentation of cutaneous lymphomas. Predisposing factors such as high temperature, high relative humidity, endogenous factors (e.g. greasy skin, sweating, heredity), drug-induced acne, immunosuppressive treatment or disorders, personal or family history of tuberculosis and neoplasia, sexual history were also investigeted.

Sorumlu yazar/ Corresponding author: Rukiye Yasak Güner, E-Mail; rky.guner@gmail.com, ORCID ID: 0000-0002-5154-4652

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There was an apple jelly appearance in lesions with diascopy. The patient's blood tests were normal and syphilis serology was negative. Serum level of angiotensin-converting enzyme was not high. Chest X-ray was normal. Purified protein derivative (PPD) skin test reaction was measured 5 mm. PCR for Mycobacterium tuberculosis was negative. Punch biopsy of the lesion was performed. Histopathological examination of the patient revealed mild hyperkeratosis in the epidermis and slight flattening in rete ridges. Granulomatous infiltration consisting of epitheloid histiocytes and multinuclear giant cells were observed in the dermis (Figure 2)

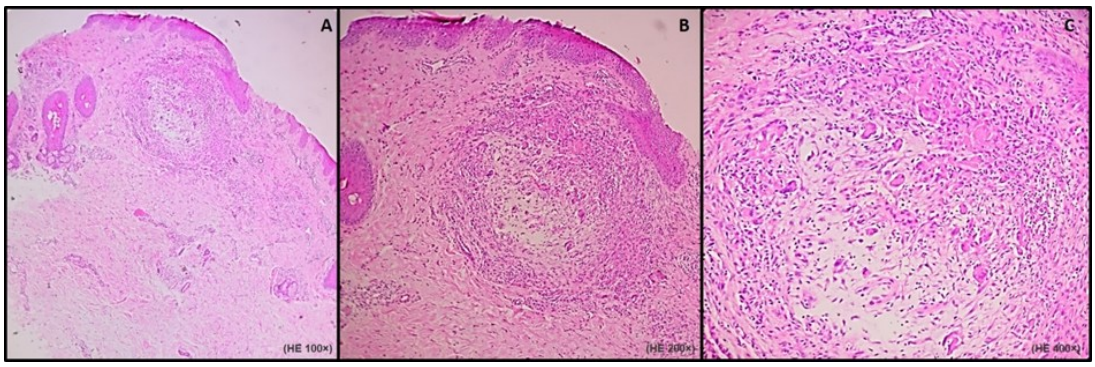

Figure 2: Chronic and granulomatous infiltration composed of epitheloid histiocytes, multiple giant cells in dermis.

When the patient was evaluated together with clinical, laboratory and histopathological findings, the patient was diagnosed as Lupus miliaris disseminatus faciei. Our patient's treatment was planned as rifampicin and isoniazid because of inability to respond to systemic steroids, antibiotics, isotretinoin. At the first month of follow-up, the lesions regressed significantly.

DISCUSSION

LMDF is considered to be a variant of lupus vulgaris or a tuberculid due to its histopathologic findings, there is no evidence to support a link between LMDF and tuberculosis. Also, LMDF is considered to be a granulomatous form of rosacea by some authors.[3,4] Dermal granulomatous infiltrates in histopathologic sections can be observed in LDMF. However histopathologic appearance (e.g. necrosis) may be changed according to the age of lesions.[5]

LMDF lesions are mostly presented on the face and extrafacial involvement is rare. Extrafacial involvement regions reported include scalp, neck, trunk, axillae, arms and genitalia.[6,7] In our patient, extrafacial involvement regions were neck, trunk, and arms.

Lesions may be regressed with years but sometimes because of potantial for scaring, appropiate early treatment may reduce scar risk.[8] Because of resistant to various therapeutic approaches, its management is often problematic. Tetracyclines are usually the first choice. Isotretionin, dapson, systemic corticotherapy, antituberculosis drugs, metronidozole, cyclosporine, tacrolimus, psolaren plus ultraviolet A, laser and photodynamic therapy can also be used [9]. Our patient's treatment was planned as rifampicin and isoniazid because of inability to respond to systemic steroids, antibiotics, isotretinoin. At the first month of follow-up, the lesions regressed significantly.

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