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Quiz

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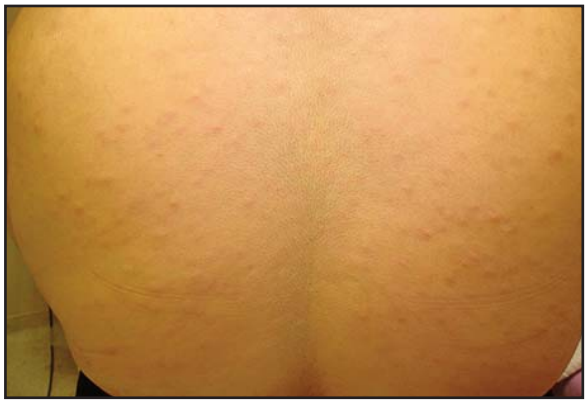
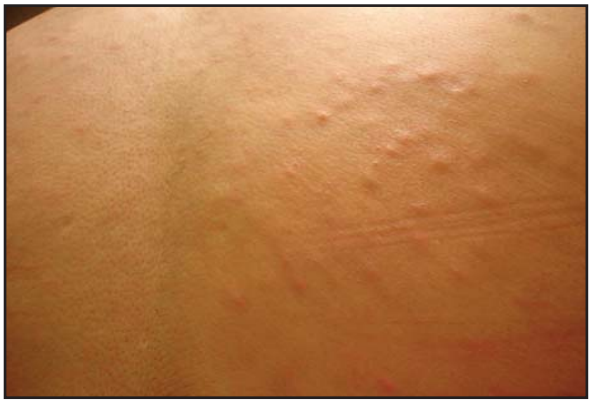
Papules on the Back





Figures 1a, 1b. Multiple skin-colored and slightly erythematous infiltrated papules

A- 40- year old woman presented with a one-month history of multiple skin colored – light erythematous, infiltrated pruritic papules on the upper back and shoulders (**Figure 1a, b**). She had shortness of breath for approximately 2 months lately. The patient was otherwise healthy except for a gastric discomfort and had received no treatment before attending our clinic.

On physical examination, multiple, skin-colored and slightly erythematous, infiltrated papules were located on the upper back and the shoulders. The oral mucosa was normal. Laboratory examinations included a complete blood cell count with differential, chemistry and urine analysis which were within normal limits. Serum level of angiotension converting enzyme (ACE) level was normal. A tuberculin skin test was negative. Erythrocyte sedimentation rate was 53 mm/hour. A 4mm- punch biopsy was performed and the specimen was sent for histopathologic examination (**Figure 2**).

A chest radiograph and chest computed tomography scan showed bilateral hilar adenopathy and infiltrations (**Figure 3**).

What is the diagnosis?

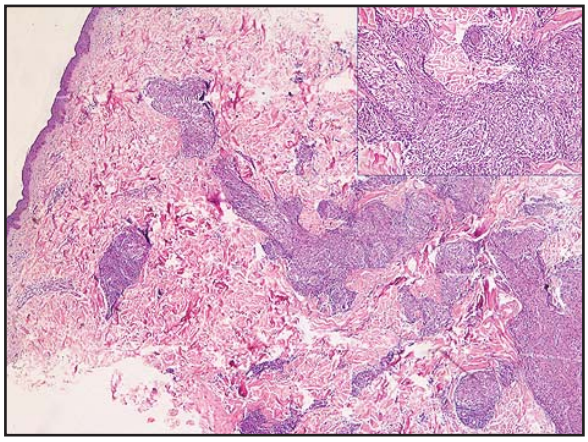


Figure 3. Histopathology demonstrating the presence of noncaseating granulomas with epithelioid cells and inflammatory infiltrate (H&E x 4, 10)

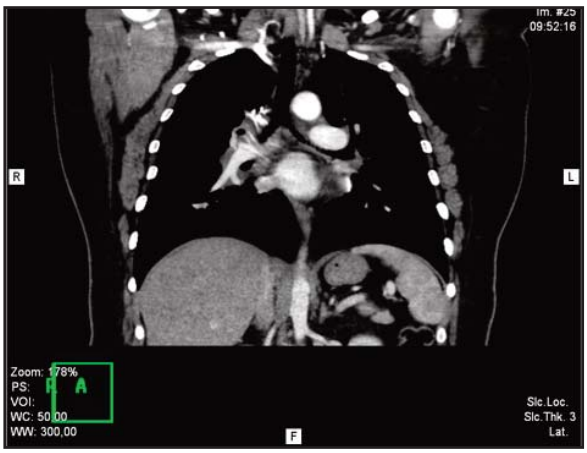


Figure 4. This section of computed tomography shows mediastinal lymphadenopathy.

Cutaneous Sarcoidosis

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Abstract

Observations: Sarcoidosis is a multisystem disease of unknown etiology. The disease most commonly affects the lungs, lymph nodes, liver, spleen, phalangeal bones, parotid glands, eyes and skin. Skin manifestations in sarcoidosis occur in about % 20-35 of patients.A-40- year old woman presented with a one-month history of multiple skin colored – light erythematous, infiltrated pruritic papules on the upper back and shoulders.

Discussion

Sarcoidosis is a multisystem disease of unknown etiology. It is characterized by the formation of the non-caseating granulomas in affected organs. The disease most commonly affects the lungs, lymph nodes, liver, spleen, phalangeal bones, parotid glands, eyes and skin [**1, 2, 3, 4**].

Skin manifestations in sarcoidosis occur in about % 20-35 of patients [**3, 4**]. Sarcoidosis is a challenging kind of disease as clinical manifestations have variable morphologies. That's why it is called as one of the " great imitator" among dermatologic diseases [**1, 4**]. Our patient had multiple infiltrative, skin-coloured, pruritic papules without any symptom except a shortness of breath.

The cutaneous manifestations can be divided into two distinct forms: specific and nonspecific skin lesions [**1, 2, 3**]. Specific lesions include papules, maculopapules, plaques, subcutaneous nodules, lupus pernio, infiltrative scars, alopecia, ulcerative lesions, ichthyosiform sarcoidosis, hypopigmentation and other very rare clinical manifestations [**3, 5**]. A histologic examination from a specific skin lesion reveales non-caseating granulomas. On the other hand the most common nonspecific lesion is erythema nodosum [**6**].

There is no specific single test for the diagnosis of sarcoidosis [**2, 3, 4**]. Cutaneous lesions are providing a visible clue to diagnosis as a source of histologic examination [**5**]. Histological analysis of skin lesions is necessary to establish the diagnosis of sarcoidosis. Actually, the final diagnosis should be made with all clinical, radiographic, laboratory and histopathological criteria [**2, 3**].

In our case, the diagnosis was made by histopathological findings of the cutaneous symptoms and was supported by radiographic images. The thorax computed tomography and chest roentgenography showed parenchymal infiltrations additional hilar lymphadenopathy so that classified as stage II according to thoracic involvement [**1**].

There are numerous therapeutic approaches for sarcoidosis. Topical, intralesional and systemic glucocorticoids are very effective agents. Many other options may be used in refractory cases, including antimalarials, methotrexate, thalidomide, isotretinoin, etanercept and infliximab [**1, 7, 8, 9**]. In our case, the treatment was made with systemic steroids with an almost complete improvement of skin lesions and respiratory symptoms. During a-four-month follow-up period, no recurrence had occurred.

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