

Resident Forum

Several Erythematous Papules with a 1.5-cm Sized Nodule Scattering on the Face of an Old Woman

Shiou-Han Wang^{1,3} Tsen-Fang Tsai^{1,2}

CASE REPORT

A 67-year-old woman presented with a 4-month history of asymptomatic papules on the face. She was a housewife with unremarkable past medical history. On physical examination, these dome-shaped papules were variably sized with erythematous hue, and some of them showed tendency to confluence. They were disseminated on the periorbital and paranasal regions. Both cheeks were also involved. A large brownish red nodule measuring 1x1.5-cm in size was noted on the right upper eyelid. Some papules were confluent and developed a 1.5-cm long transverse nodule on the left upper eyelid (Fig. 1). A biopsy was taken from the right eyelid and sent for histopathologic examination, including acid-fast stain and diastase periodic acid Schiff reaction (Fig. 2). Microscopic examination showed granulomatous inflammation with perifollicular granulomas and focal caseous necrosis in the dermis. Neither mycobacterial bacilli nor hyphae of fungi were demonstrated.

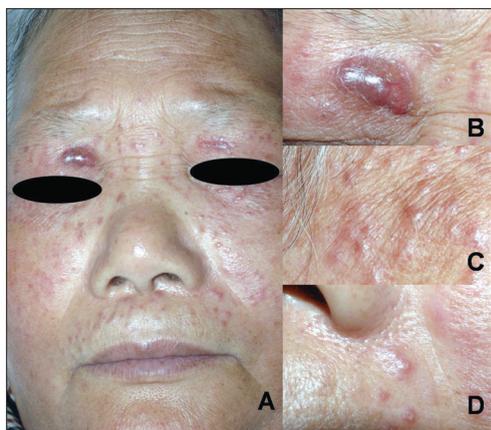


Fig. 1
(A) Variably sized erythematous dome-shaped papules on the face with tendency to confluence. (B) A large brownish red nodule measuring 1x1.5-cm in size on the right upper eyelid. (C) Cheeks involvement. (D) Scattered papules on the periorbital and paranasal regions.

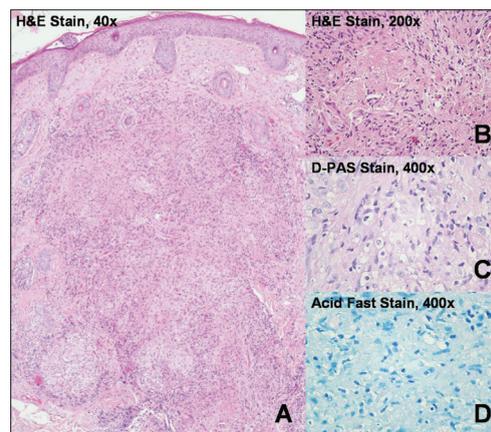


Fig. 2
(A)(B)(C)(D) The histopathology and special stain of the nodule on the right upper eyelid and the papule on the periorbital region showed similar findings with superficial perifollicular granulomatous inflammation and caseous necrosis. (C)(D) Stains for mycobacterial bacilli and hyphae of fungi demonstrated negative results.

From the Department of Dermatology, National Taiwan University Hospital¹ and College of Medicine,² National Taiwan University, Graduate Institute of Biomedical Electronics and Bioinformatics, College of Electrical Engineering and Computer Science, National Taiwan University³

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Reprint requests: Tsen-Fang Tsai, M.D., Department of Dermatology, National Taiwan University Hospital; 7, Chung-Shan South Road, Taipei 100, Taiwan

TEL: 886-2-23562141 FAX: 886-2-23934177 E-mail: tfisai@ha.mc.ntu.edu.tw, tfisai@yahoo.com

王修含

DIAGNOSIS: *Acne Agminata (lupus miliaris disseminatus faciei, LMDF)*

DISCUSSION

LMDF, as known as acne agminata, is a self-limited disease of unknown etiology. LMDF usually occurs on the face, but extrafacial presentations have been reported.^{1,2} It clinically shows discrete brown papules of diameter about 1-3 mm.³ A 1.5 cm nodular lesion was present in this case, which is a rare feature. It is characterized by superficial granulomatous inflammation with central caseation necrosis in the perifollicular granulomas.¹

LMDF may have a multifactorial aetiology. Mycobacterium tuberculosis or its products may cause a caseous necrosis and thus maybe one of several possible causes.⁴ Some authors view LMDF as a variant of granulomatous rosacea or a presentation related to Demodex folliculitis. Others suggest it as a new independent entity and proposed a new term: Facial Idiopathic Granulomas with Regressive Evolution (FIGURE).¹ Misago *et al.* postulated LMDF as a common adult form, granulomatous periorificial dermatitis as a rare childhood form, and perioral dermatitis as a peculiar form exacerbated by topical corticosteroids.⁵

There are no randomized controlled studies available for the treatment of LMDF. The usual first-line therapy is oral tetracyclines with variable success rates. Dapsone, low dose prednisolone, clofazimine and isotretinoin have all been tried in some cases.^{6,7} Our case was treated with a regimen of oral tetracycline (1000 mg/d). The skin lesions showed satisfactory response to this therapy subjectively by the patient, and most papules resolved successfully with sequela of scarring after 8 months of treatment. Recently, the 1450-nm diode laser has been shown to improve LMDF.⁷

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