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SHORT COMMUNICATIONS

UNUSUAL CLINICAL AND HISTOPATHOLOGICAL PRESENTATION OF FACIAL TUBERCULOSIS

Adarsh Chopra, S S Gill, Chanchal Jain, Kiranjot, Dimple

Atypical facial lupus vulgaris is described in two cases. The first case resembled sarcoidosis clinically and histologically but responded well to ATT. The second case whose clinical diagnosis of lupus vulgaris was confirmed therapeutically had an atypical histology.

Key Words: Lupus vulgaris, Tuberculosis, Anti-tubercular therapy

Introduction

Tuberculosis is one of the commonest chronic granulomatous cutaneous infections. It presents in a variety of morphological forms classified as primary, secondary or reinfection and tuberculides.Out of secondary tuberculosis lupus vulgaris (LV) is reported to be the commonest.[1] Since the advent of National Tuberculosis Control Programme,[2] the incidence of tuberculosis has gone down but variations have cropped up in the clinical and histopathological appearances which make the diagnosis difficult and delayed. Possible reasons for these changes may be: (i) Bacilli are destroyed and become non-viable, (ii) skin lesions may present a reaction pattern to some antigenic components of the bacilli, (iii) bacilli may exist in different forms. We are reporting 2 such cases of LV posing problems of diagnosis and delay in treatment.

Case Reports

Case I : A 50-year-old male presented in Sept 1993 with a mildly itchy purplish erythematous plaque over left side of forehead for the past one year. He had taken various forms of treatment without relief. After 14 months, he developed two similar nodules on right side of forehead and one plaque over bridge of the nose. There was no history of trauma/insect bite prior to onset of lesions and no symptoms of any other chronic illness. The patient was diabetic. General physical examination was normal. BCG scar was present. On local examination, bilateral asymmetrical noduloplaques with well-defined margins and slight scaling with satellite papules at the periphery were seen.No apple jelly nodules, atrophic scarring or telangiectasis were seen. There were follicular prominences over alae nasi. Laboratory investigations were within normal limits except for fasting blood sugar 170 mg% with urine sugar 1%. Mantoux test was negative.X-ray chest revealed:(i) accentuation of bronchovascular markings, (ii) bilateral hilar calcification, (iii) enlarged hila, (iv) clear apices.Biopsy showed epitheloid cell granuloma. X-ray and biopsy findings favoured diagnosis of sarcoidosis. He was put on prednisolone 20 mg daily for one month but no improvement occurred. Then he was put on anti-tubercular therapy (INH and Streptomycin). Clinical improvement started within one week in form of decreased erythema and regression of lesions at the

From the Department of Skin and VD, Government Medical College, Patiala-147001, India.

Address correspondence to : Dr Adarsh Chopra 27-Bank Colony, Patiala-147001.

periphery.He continued it for one year and there was complete disappearance of the lesions. Follow up was done for one year but no reappearance of the lesions has occurred.

Case II: A 30-year-old female presented with asymptomatic papulo-nodular lesions forming a plaque over nose extending to the upper lip of 1½ year duration.The lesion started as small erythematous papule over tip of nose which subsequently enlarged to involve both alae nasi and mucous membrane of the upper lip. There was no telangiectasis, no scarring, no apple jelly nodules but oozing and crusting were present. Margins of lesion showed erythematous papules but no pigmentation. No family or personal history of tuberculosis was present. BCG scar was present. All investigations were within normal limits. Mantoux test was +++. X-ray chest showed no abnormality. Skin biopsy revealed multiple granulomas in the dermis with lot of caseation necrosis and few Langhans giant cells at the periphery, but no epithelioid cells were seen. Patient was put on rifampicin and isoniazid. The lesions started regressing after 15 days of therapy and complete recovery was seen after 6 months.

Discussion

Cutaneous tuberculosis can present with unusual clinical and histological features leading to a delay in diagnosis.[3] Our first patient had abnormal clinical picture, X-ray findings and naked granulomas without caseation necrosis but he did not respond to oral steroids. Our second patient did not show any tuberculoid granuloma instead she had only caseation necrosis with Langhans giant cells but she also responded well to ATT. As newer tests like radio-immuno assays and enzyme-linked immunosorbent assays (ELISA) to detect mycobacterial antigen are not freely available, in all atypical granulomatous lesions of the face tuberculosis must be kept in mind and in non-healing granulomatous lesions ATT should be tried.

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