Ind J Dermatol Venereol Leprol 1996; 62 : 371-72

LUPUS MILIARIS DISSEMINATUS FACIEI

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Lupus miliaris disseminatus faciei also known as acne agminata is a rare disease affecting face in adults. Previously, it was thought to be a tuberculid; and its relation with rosacea is undefined. We report a case who had multiple yellowish brown to erythematous small papular lesions and many pitted atrophic scars on the face of 8 months duration. Investigations for tuberculosis were negative. Histopathology revealed tuberculoid granuloma.

Key Word : Acne agminata

Introduction

Lupus miliaris disseminatus faciei (LMDF) is a rare disease of acquired origin commonly affecting the face with papular eruption in adults of both sexes. Originally LMDF was thought to be a tuberculid.[1] In spite of tuberculoid pathology, tuberculin test is mostly negative and culture for mycobacteria is sterile from the lesions. There is no concomitant tuberculosis and there is no response to antitubercular drugs. The course of the disease is chronic self limited and leads to spontaneous involution.

Case Report

A 22-year-old female presented with multiple yellowish brown erythematous papular lesions and many pitted atrophic scars on the face of 8 months duration. There was history of homeopathic medication for nasobronchial allergy for 3 months prior to the onset of disease. She took treatment for this skin ailment in the form of metronidazole (oral and topical), minocycline, acnex lotion locally, and vitamin A oral tablets. She continued with this treatment for 3 months but without any relief and new lesions continued to appear. There was no history suggestive of pulmonary Kochs or any cutaneous tuberculosis in the past or present.

On examination, multiple scattered yellowish brown to erythematous, firm, asymptomatic papules were present on the cheeks, eyebrows, forehead and in the scalp (Fig.1). The size of the lesions was about 0.5 cm in diameter. There were also seen pock-like scars scattered over the face indicating old healed lesions. Partial alopecia was also seen

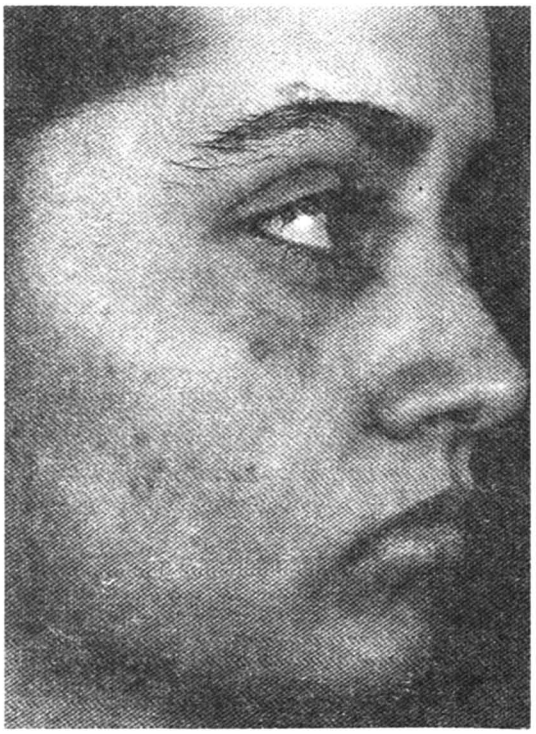

Fig. 1. Papular lesions and pock-like scarring on the face.

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over the eyebrows where lesions had healed. Clinically chest examination was normal.

Haematological profile, urine complete examination, blood sugar, blood urea, tuberculin test were within normal limits. X-ray chest was also normal Histopathology from one of the lesions showed a normal looking epidermis with dermal tissue showing diffuse infiltration with mononuclear cells and in deeper region amidst eosinophilic necrotic tissue, infiltration with epithelioid cells and occasional Langhan's type of giant cells were seen. AFB were not detected. From histopathology a diagnosis of LMDF was made.

The patient was put on prednisolone (5 mg) three times a day for 7 days. On follow up, after 7 days we found that there was no change in the old lesions but at the same time no new lesion appeared. Patient was advised to take prednisolone (5 mg) twice a day for next 7 days followed by one tablet once a day for next 7 days. On follow up at 3 weeks, we found that all the old lesions started regressing and no new lesion came up. Patient was advised to continue one tablet of prednisolone (5 mg) daily for another 3 weeks. On follow up at 6 weeks, all the old lesions showed regression, but at the same time 2 new lesions also came up. Tab prednisolone was stopped and patient was put on tablet dapsone 100 mg/day for 3 weeks. On follow up after 3 weeks patient was found symptom free except for few pock like scars and patient was further advised to continue with the same treatment for another 3 weeks and is still under follow up.

Discussion

The cause and pathogenesis of LMDF is not known. Clinically lesions may resemble rosacea but its exact relation with rosacea remains undefined.[2] It cannot be considered as tuberculid because there is no evidence of active tubercular pathology elsewhere in the body, tuberculin test is negative, and culture for AFB is sterile.[3] Other view regarding its pathogenesis is that it is a foreign body type of reaction to sebum,[4] follicular contents or cysts.[5]

The natural history is one of the eventual resolution in 12-24 months with pock-like scarring as was seen in our case.

In the differential diagnosis, rosacea and acne vulgaris can be distinguished by their distribution and polymorphous clinical picture. Sarcoidosis and papular form of granuloma annulare should also be considered.[2]

Oral steroids and dapsone shorten the expected natural duration of the disease and prevent the eruption of new papules.[2]

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