ISSN 0378-6323
E-ISSN 0973-3930

Indian Journal of Dermatology, Venereology & Leprology

Vol 74 | Issue 1 | Jan-Feb 2008

The Indian Journal of Dermatology, Venereology and Leprology (IJDVL) is a bimonthly publication of the Indian Association of Dermatologists, Venereologists and Leprologists (IADVL) and is published for IADVL by Medknow Publications.

The Journal is **indexed/listed** with Science Citation Index Expanded, PUBMED, EMBASE, Bioline International, CAB Abstracts, Global Health, DOAJ, Health and Wellness Research Center, SCOPUS, Health Reference Center Academic, InfoTrac One File, Expanded Academic ASAP, NIWI, INIST, Uncover, JADE (Journal Article Database), IndMed, Indian Science Abstract's and PubList.

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E-mail: editor@ijdvl.com

Published for IADVL by
MEDKNOW PUBLICATIONS
A-109, Kanara Business Centre, Off Link Road, Ghatkopar (E), Mumbai - 400075, India.
Tel: 91-22-6649 1818 / 1816
Website: www.medknow.com

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Indian Journal of
Dermatology, Venereology & Leprology
Journal indexed with SCI-E, PubMed, and EMBASE
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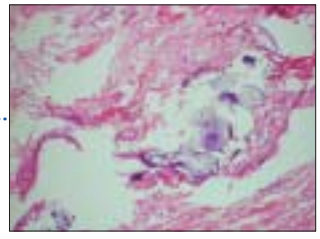
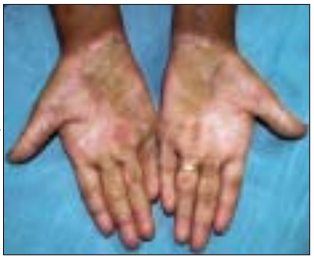
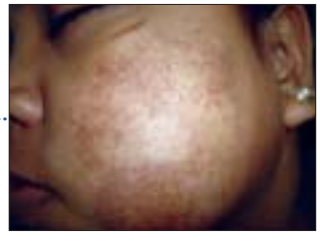
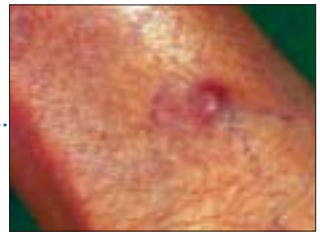
CONTENTS

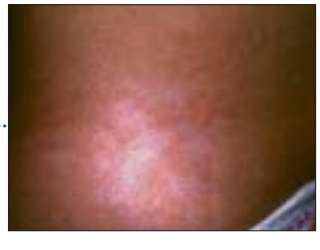


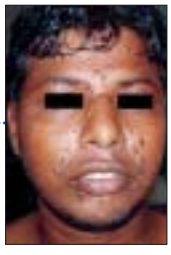


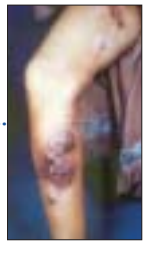


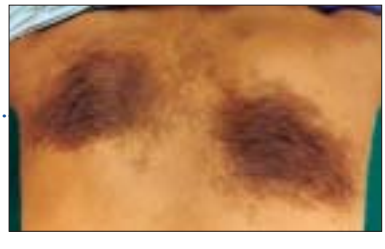


LETTERS TO THE EDITOR









FOCUS

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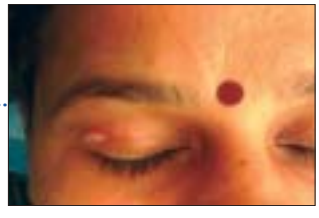
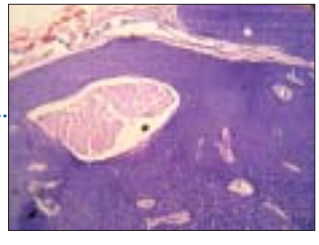


QUIZ



Asymptomatic erythematous plaque on eyelid

A 30-year-old Indian woman presented with 1-year history of erythematous, mildly scaly plaque on right eyelid. The lesion started as a small papule, which gradually evolved into a plaque. The lesion was asymptomatic and there were no ocular complaints. Past medical history was insignificant and the patient gave no history of preceding trauma. She was otherwise healthy. Examination revealed a 2×1 cm erythematous, mildly scaly, indurated plaque with irregular well-defined border on right eyelid [Figure 1]. A small depressed area of scarring was present on the lesion. There was no lymphadenopathy. A skin biopsy specimen was obtained [Figures 2-3].

WHAT IS YOUR DIAGNOSIS?

For images of the quiz and the answer, visit www.ijdvl.com

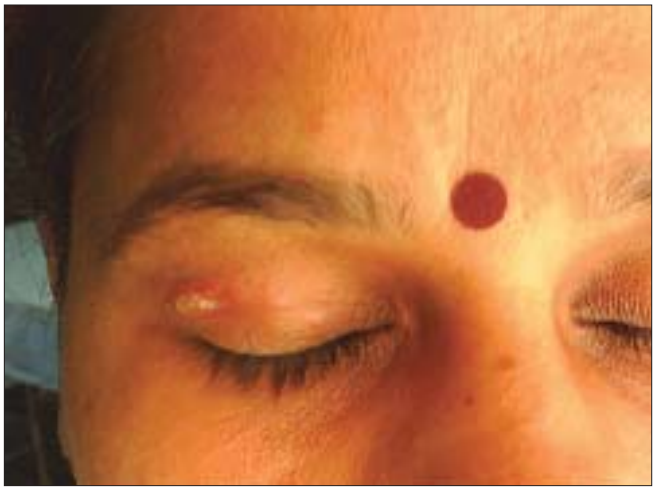


Figure 1: Erythematous plaque on right eyelid

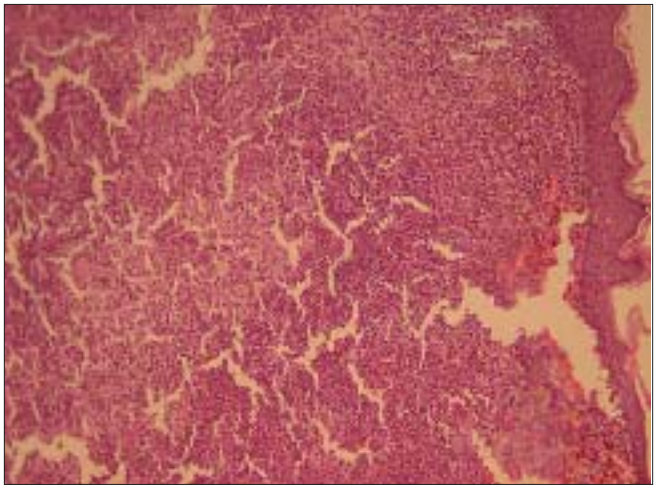


Figure 2: Diffuse dense granulomatous infiltrate (H and E stain, X100)

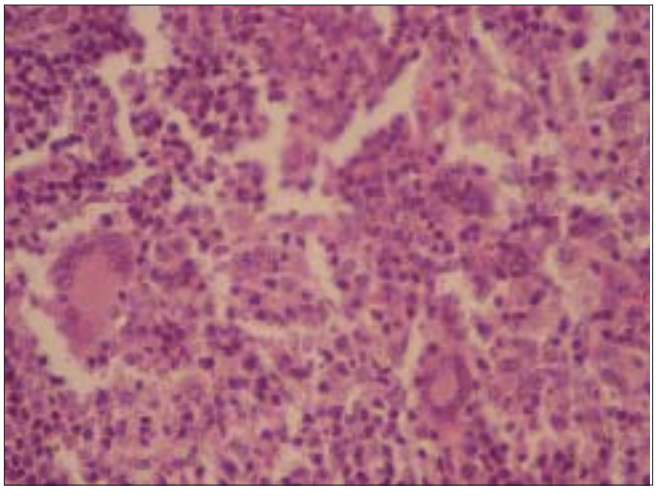


Figure 3: Giant cells within the granuloma (H and E stain, X400)

How to cite this article: Sanjay Singh. Asymptomatic erythematous plaque on eyelid. Indian J Dermatol Venereol Leprol 2008;74:82.
Received: November, 2007. **Accepted:** April, 2007. **Source of Support:** Nil. **Conflict of Interest:** None declared.

Figure 4: Clinical photograph after 2 months of treatment

Diagnosis: Lupus vulgaris

Histopathological examination showed diffuse dense tuberculoid granulomatous infiltrate made up of lymphocytes, plasma cells, histiocytes and epithelioid cells with Langhan's giant cells. Lymphocytes and plasma cells were present in overwhelming majority, giving an appearance of lymphoid infiltrate. There were areas showing caseous necrosis. Overlying epidermis showed moderate spongiotic psoriasiform change. Mantoux test, done after the biopsy result, was strongly positive (10 × 20 mm) and X-ray chest was normal. The patient was prescribed antitubercular treatment with four drugs (isoniazid, rifampicin, pyrazinamide, ethambutol) for 2 months, followed by isoniazid and rifampicin for 4 months. The lesion had healed considerably by 2 months [Figure 4].

DISCUSSION

Lupus vulgaris, the commonest type of cutaneous tuberculosis, is a chronic, progressive disease occurring in individuals with moderate-to-high degree of immunity and high degree of tuberculin sensitivity. Prevalence of cutaneous tuberculosis has declined considerably in both developing and developed countries in the last few decades after the availability of effective antituberculosis treatment. The disease is so rare in developed countries that the term 'lupus' usually means lupus erythematosus and not lupus vulgaris.[1]

All age groups are affected. Different studies have shown different sex distribution of cases (females[2,3] or males[4] being more commonly affected), as well as different sites being predominantly affected (buttocks, thighs and legs[2]; or head and neck[3,4]). The characteristic lesion is a plaque composed of reddish brown nodules, which on diascopy reveal an 'apple jelly' color.[1] The disease process is usually associated with scarring and atrophy, causing considerable tissue destruction over many years. The diagnosis of lupus vulgaris is confirmed by histopathology.

On the face, lupus vulgaris tends to involve the nose, earlobes and upper lip.[1] Lupus vulgaris on eyelid alone has been reported only once.[5] Clinically, we kept the differential diagnosis of psoriasis, lupus vulgaris and eyelid dermatitis in the present case. An early diagnosis and treatment is needed to prevent disfigurement, which on an eyelid can lead to scarring and fixity of eyelid with resultant exposure keratitis and decreased vision.

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