

Lupus vulgaris: An atypical presentation

A 60 year old male, farmer by occupation, presented with one year history of an asymptomatic lesion on his right hand. The lesion started as a red nodule on the tip of the thumb one year back and gradually involved both sides of his hand. Cutaneous examination revealed an area of hyperkeratosis on the right palm and large thick adherent crusts on an erythematous base on the dorsal aspect [Figure 1a]. The nail plates were curved and the keratinized material around the nails was shaped like cutaneous horns [Figure 1b]. There was erythema, scarring and atrophy in between the areas of hyperkeratosis. A well defined plaque with similar crusting and erythema was present on the right upper arm. There was no regional or generalized lymphadenopathy. There was no systemic complaint. The general physical and systemic examinations were within normal limits. Histopathology of lesional skin from hand revealed mild hyperplasia of epidermis with multiple caseating granulomas containing Langhans giant cells and epithelioid cells in the dermis. A tissue smear for LD bodies was done to rule out cutaneous leishmaniasis and it was negative. PCR from the lesional skin specimen from hand was positive for mycobacterium tuberculosis. Chest x-ray revealed bilateral apical cavities in lungs and sputum

was positive for acid fast bacilli. Mantoux test was strongly positive. There was no past history of anti-tubercular treatment. The patient was diagnosed as a case of lupus vulgaris with underlying pulmonary tuberculosis and was put on category I, DOTS regimen for six months. There was dramatic improvement in the skin lesions after six weeks of treatment [Figure 2]. There was marked reduction in erythema, crusts and keratinization around the nails.

Lupus vulgaris is a progressive form of cutaneous tuberculosis occurring in a person with moderate to high degree of immunity. It develops as a result of direct inoculation, direct extension from an underlying organ or by lymphatic spread. Rarely, it can occur as a result of haematogenous spread from an infective focus. The common sites of involvement are head and neck followed by arms and legs. The lesion is usually single and starts as a tiny reddish-brown nodule, which later becomes raised and infiltrated. Clinically lupus vulgaris presents in five general patterns: plaque form, ulcerative and mutilating form, vegetating form, tumor like form and papular and nodular form. In plaque form, there is well defined border with little infiltration and scaling and minimal scarring in the



Figure 1a: Large, thick and adherent crusts on dorsum of the hand



Figure 1b: Hyperkeratosis, erythema and horny accumulation around the nails, nail plates are curved

How to cite this article: Hassan I, Ahmad M, Masood Q. Lupus vulgaris: An atypical presentation. Indian J Dermatol Venereol Leprol 2010;76:180-1.

Received: August, 2009. **Accepted:** January, 2010. **Source of Support:** Nil. **Conflict of Interest:** None declared.



Figure 2: Lesions on both sides of the hand showed marked improvement after six weeks of antitubercular treatment

centre. In ulcerating form, crusts form over the areas of necrosis and scarring and ulceration predominates. Vegetating form is characterized by marked ulceration and extensive infiltration.

The tumor-like form presents as a deep infiltration in the form of soft and smooth grouped nodules or a reddish-yellow plaque. In papular and nodule type, multiple lesions occur in disseminated pattern. Besides these clinical types of lupus vulgaris, atypical forms are becoming more common.

In our case, large thick adherent crusts on the dorsum of hand with minimal ulceration were present. There was no destruction of the underlying tissue. The areas of hyperkeratosis and horny accumulation of keratinized material around the nails were peculiar findings in our case. Response to antitubercular treatment was excellent in our patient.

Iffat Hassan, Mashkoor Ahmad, Qazi Masood

Department of Dermatology, STD & Leprosy, Govt. Medical College and Associated SMHS Hospital, Srinagar-Kashmir (J&K), India

Address for correspondence: Dr. Iffat Hassan,
Department of Dermatology, STD & Leprosy, Govt. Medical College and Associated SMHS Hospital, Srinagar-Kashmir (J&K), India. E-mail: hassaniffat@gmail.com

DOI: 10.4103/0378-6323.60571 -