

Granulomatous rosacea in Cornelia de Lange syndrome

Sir,

Cornelia de Lange syndrome (CDLS) is a multisystem disorder characterized by a typical facial appearance, prenatal and postnatal growth retardation, feeding difficulties, psychomotor delay, and behavioral problems. Facial features include cutis marmorata and bluish discoloration of the face, synophrys (confluent eyebrows) along with hypertrichosis. The hirsutism includes long and curly eyelashes and confluent eyebrows. Most patients are born with a noticeable generalized hypertrichosis, especially involving the nape of the neck, the lateral aspects of the elbows, and the lower sacral area.^[1] Skeletal abnormalities and an abnormal cry are also manifestations of CDLS. Dermatological manifestations of CDLS have been reviewed,^[1-4] but rosacea has not been reported. Most of the dermatological manifestations appear at birth or present shortly thereafter.^[1] Keratosis pilaris atrophicans faciei (ulerythema ophryogenes) has been reported in CDLS.^[5] We report a patient with granulomatous rosacea and CDLS; this association has not previously been reported.

A 16-year-old girl with CDLS presented with a 6-month history of a facial rash; this rash was sore, was worsened by sunlight, and was distributed in a 'V' shape over her neck and upper chest. It extended to involve the cheeks, lips, and chin. She had been born at 42 weeks weighing 2.24 kg to healthy, nonconsanguineous parents. The parents noticed that since birth she had difficulty in feeding, refusing bottle feeding and failing to grow normally. She was started on tube feeding at 4 weeks, which continued for three years. There was a delay in maturation of her teeth. She had been taking omeprazole 20 mg, twice daily, for gastroesophageal reflux. She did use some topical steroids initially, but has also been using miconazole and E45 emollient; none of these has been helpful.

Examination revealed significant growth and mental retardation. Characteristic features of CDLS present included hypertrichosis, slanting eyes, synophrys, prominent long eyelashes, depressed nasal bridge with anteverted nostrils, increased nose-lip distance, thin lips turned down at the corners, and micrognathia. Cutaneous examination revealed some hypertrichosis of the arms and of the mid lower back. She had a

low hairline. There were multiple confluent papular erythematous lesions on the cheeks, lips, and chin distributed in a butterfly pattern [Figure 1]. No comedones were seen. There were no inflammatory eye changes.

The differential diagnosis included lupus erythematosus, rosacea, acne, ulerythema ophryogenes, granulomatous periorificial dermatitis, and lupus miliaris disseminatus faciei (acne agminata).

Blood investigations showed antinuclear antibody (ANA) negative, anti-dsDNA antibodies level normal at 9 IU/mL, normal plasma porphyrin concentration, and no porphyrin detected by fluorescence, thereby, excluding all cutaneous porphyrias. A 4-mm punch skin biopsy from the face showed some dilated dermal

capillaries and a mixed patchy chronic interfollicular inflammatory infiltration with loosely formed granulomas, consistent with rosacea [Figure 2]. Direct immunofluorescence was negative. The diagnosis of rosacea was made based on the clinical features, supported by histological findings consistent with granulomatous rosacea.

The parents of the patient were advised to help her avoid sun exposure and extreme temperature, and to help her apply a high sun protection factor sunscreen when exposed to sunlight. Topical 0.75% metronidazole, twice daily, was prescribed. Two months later, the eruptions showed some improvement.

We believe that our patient with CDLS had granulomatous rosacea that was partially controlled with metronidazole. However, all the differential diagnoses mentioned above should be considered with these clinical features. CDLS has several distinct dermatological manifestations including hirsutism and cutis marmorata, which are well described in the dermatological literature. The lack of previous reports of rosacea occurring in CDLS suggests that the association may be coincidental, there is unlikely to be any identifiable etiopathological connection. However, we hope that knowledge among dermatologists of the specific dermatological manifestations of CDLS may alert physicians to this rare condition, and allow more appropriate management when identified.



Figure 1: Face of patient with characteristic Cornelia de Lange facies and the erythematous facial rash

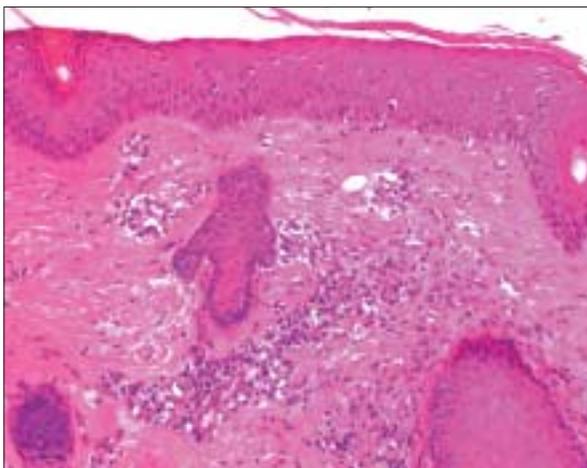


Figure 2: Histology of biopsy from left cheek, high power showing dilated dermal capillaries and mixed patchy interfollicular lymphohistiocytic infiltrations with loose granulomas. (H&E, x100)

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