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is a bimonthly publication of the Indian Association of Dermatologists, Venereologists and Leprologists (IADVL) and is published for IADVL by Medknow Publications.

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**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  
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# Indian Journal of Dermatology, Venereology & Leprology

Journal indexed with SCI-E, PubMed, and EMBASE

Vol 74 | Issue 1 | Jan-Feb 2008

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A clinico-epidemiological study of PLE was done for a period of one year to include 220 cases of PLE of skin type between IV and VI. The manifestation of PLE was most common in house wives on sun exposed areas. Most of the patients of PLE presented with mild symptoms and rash around neck, lower forearms and arms which was aggravated on exposure to sunlight. PLE was more prevalent in the months of March and September and the disease was recurrent in 31.36% of cases.

### Comparative study of efficacy and safety of hydroxychloroquine and chloroquine in polymorphic light eruption: A randomized, double-blind, multicentric study

Anil Pareek, Uday Khopkar, S. Sacchidanand, Nitin Chandurkar, Geeta S. Naik ..... 18

In a double-blind randomized, comparative multicentric study evaluating efficacy of antimalarials in polymorphic light eruption, a total of 117 patients of PLE were randomized to receive hydroxychloroquine and chloroquine tablets for a period of 2 months (initial twice daily dose was reduced to once daily after 1 month). A significant reduction in severity scores for burning, itching, and erythema was observed in patients treated with hydroxychloroquine as compared to chloroquine. Hydroxychloroquine was found to be a safe antimalarial in the dosage studied with lesser risk of ocular toxicity.

**Many faces of cutaneous leishmaniasis**

Arfan Ul Bari, Simeen Ber Rahman .....

Symptomatic cutaneous leishmaniasis is diverse in its presentation and outcome in a tropical country like Pakistan where the disease is endemic. The study describes the clinical profile and atypical presentations in 41 cases among 718 patients of cutaneous leishmaniasis. Extremity was the most common site of involvement and lupoid cutaneous leishmaniasis was the most common atypical form observed. Authors suggest that clustering of atypical cases in a geographically restricted region could possibly be due to emergence of a new parasite strain.



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**Forehead plaque: A cutaneous marker of CNS involvement in tuberous sclerosis**

G. Raghu Rama Rao, P. V. Krishna Rao, K. V. T. Gopal, Y. Hari Kishan Kumar, B. V. Ramachandra .....

In a retrospective study of 15 patients of tuberous sclerosis, eight patients had central nervous system involvement. Among these 8 cases, 7 cases had forehead plaque. This small study suggests that presence of forehead plaque is significantly associated with CNS involvement.

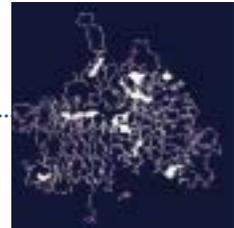


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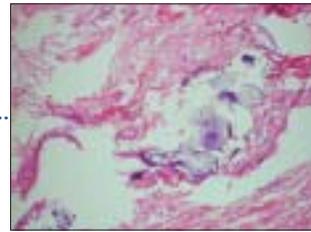
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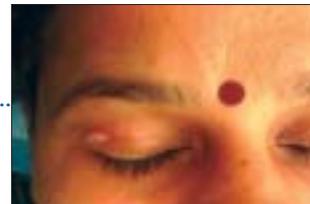
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## Asymptomatic erythematous plaque on eyelid

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](http://www.ijdvl.com)



Figure 1: Erythematous plaque on right eyelid

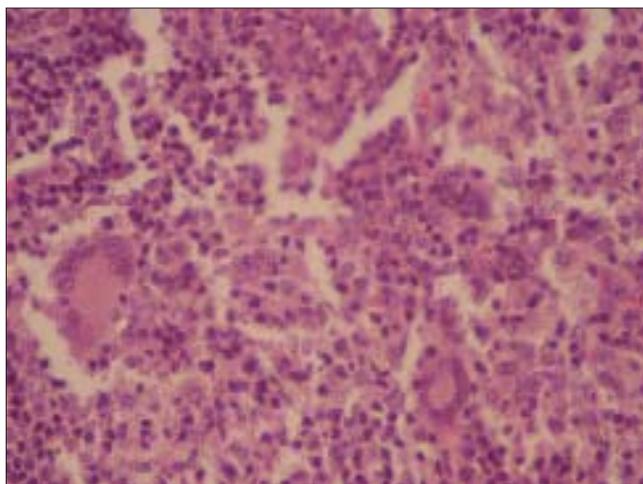


Figure 3: Giant cells within the granuloma (H and E stain, X400)

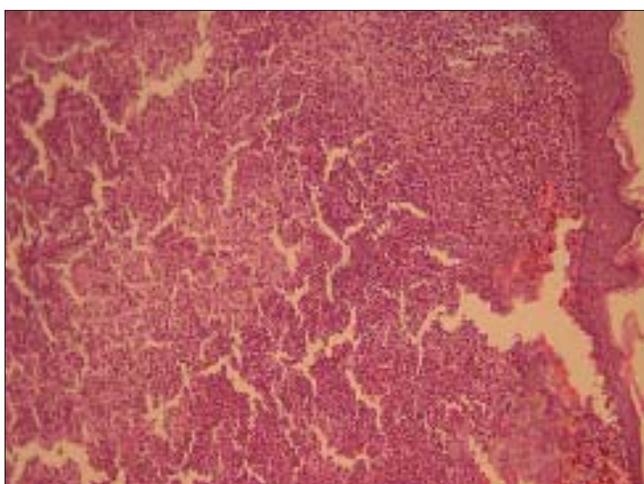


Figure 2: Diffuse dense granulomatous infiltrate (H and E stain, X100)

**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.<sup>[1]</sup>

All age groups are affected. Different studies have shown different sex distribution of cases (females<sup>[2,3]</sup> or males<sup>[4]</sup> being more commonly affected), as well as different sites being predominantly affected (buttocks, thighs and legs<sup>[2]</sup>; or head and neck<sup>[3,4]</sup>). The characteristic lesion is a plaque composed of reddish brown nodules, which on diascopy reveal an 'apple jelly' color.<sup>[1]</sup> 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.<sup>[1]</sup> Lupus vulgaris on eyelid alone has been reported only once.<sup>[5]</sup> 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.

**Neeraj Srivastava, Lakhan Singh Solanki,  
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### REFERENCES

1. Mahajan VK, Sharma NL, Sharma RC. Were-wolf cutaneous tuberculosis. *Int J Lep Other Mycobact Dis* 2004;72:473-9.
2. Singh G. Lupus vulgaris in India. *Indian J Dermatol Venereol Leprol* 1974;40:257-60.
3. Tappeiner G, Wolff K. Tuberculosis and other mycobacterial infections. *In: Freedberg IM, Eisen AZ, Wolff K, Austen KF, Goldsmith LA, Katz SI, editors. Fitzpatrick's dermatology in general medicine. 6<sup>th</sup> ed. McGraw-Hill: New York; 2003. p. 1933-50.*
4. Acharya KM, Ranpara H, Dutta R, Mehta B. A clinicopathological study of 50 cases of cutaneous tuberculosis in Jamnagar District. *Indian J Dermatol Venereol Leprol* 1997;63:301-3.
5. Bhaduri G, Gangopadhyaya DN. Lupus vulgaris at a rare site. *Indian J Dermatol* 1999;44:195-6.