

Cutaneous Sarcoidosis Treated as Seborrheic Dermatitis

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Introduction

Sarcoidosis is a multisystem disorder characterised by non-caseating granulomas in various organs and tissue. Common sites include the lymph nodes, lungs, spleen, liver, eyes, skin and joints. Cutaneous sarcoidosis is rare in Asia, and can occur in approximately 25 percent of patients, with vastly heterogeneous morphologic manifestations [1,2]. Skin manifestations of sarcoidosis can be disfiguring, have prognostic importance, and may not be readily diagnosed even by dermatologists [3]. We present a case of cutaneous sarcoidosis in Asia, initially treated as seborrheic dermatitis and responding to systemic therapy involving glucocorticoid and hydroxy chloroquine.

Image and Discussion

A 26-year-old Indian lady presented with a 5-month history of an itchy rash on the face. She was previously treated as seborrheic dermatitis with 1% Bethamethasone Valerate cream, Clobetasone and Tacrolimus ointment, however reported worsening of the rash. Review of systemic symptoms was unremarkable.

Physical examination revealed infiltrative erythematous papules and plaques over her eyelids and central face, including the nasolabial folds and perioral regions (**Figures 1 and 2**). The tip of the nose was spared. There were no annular lesions, nodules, crusting, pustules, telangiectasia or cervical lymphadenopathy. Rest of the cutaneous examination was unremarkable.

Skin biopsy over her left nasolabial fold revealed non-caseating granulomas with dermal aggregates of epithelioid histiocytes and lymphocytic multinucleated giant cells. Stains for acid fast bacilli (AFB), Fungus and Leprobacilli were negative, along with tissue cultures for AFB and fungal elements. There was no polarisable material detected. A rheumatology consult was sought to evaluate involvement of other organ systems. Eye examination, lung and renal function, chest radiograph and TB Quantiferon tests were normal.

Our patient was treated with daily Hydroxy chloroquine 200 mg and tapering doses of Prednisolone starting from 30 mg a day. There was 80% clearance of lesions at the end of 3 months without scarring.

Cutaneous sarcoidosis is notably rare in an Asian population, however it should be considered in patients with infiltrative lesions in a seborrheic distribution. In general, treatment of

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cutaneous sarcoidosis is reserved for patients with cosmetically disfiguring, symptomatic, ulcerating, or progressively worsening skin disease. Few randomized trials have compared the efficacy of treatment strategies [4-6]. In our patient, aggressive treatment with systemic therapy upon failing topical treatment may have caused the lesions to heal without scarring. Despite the low prevalence of sarcoidosis in Asia and an even smaller percentage of patients with cutaneous manifestations, attention must be



Figure 1 Indurated erythematous papules and plaques surrounding nasolabial and perioral regions



Figure 2 Infiltrative papulonodular lesions over bilateral eyelids

spent on careful diagnosis and evaluation of systemic involvement. Further monitoring after treatment response is essential in view of possible relapse and subsequent systemic involvement [7,8].

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