Sir,
Granulomatous facial dermatoses share the common histological features of epithelioid cell granulomas. In the pediatric age group, important differentials to keep in mind are childhood granulomatous perioral dermatitis (CGPD), granulomatous rosacea (GR), papular sarcoidosis, peri-oral dermatitis (POD), and lupus miliaris disseminatus faciei (LMDF). Herein, we report a case of LMDF.

Case: A 12-year-old boy presented with multiple asymptomatic erythematous lesions over his face for 1 year. History of photosensitivity was absent. There were no extra-facial lesions, systemic complaints, and no significant family history. He was treated with topical steroids for 2 months with minimal improvement. Examination revealed multiple, discrete pinkish to erythematous monomorphic papules of 1 to 4 mm size, clustered over both cheeks and, a few papules scattered around the eyes, nose, forehead, and bilateral pinna [Figure 1a and b]. There was no background of erythema or telangiectasia.

A differential diagnosis of CGPD, LMDF, and papular sarcoidosis was considered.

Investigations: Mantoux test with 5TU of tuberculin PPD RT23 done on the left forearm showed negative at 48 and 72 h (no induration or erythema observed). The chest X-ray was normal. Work-up for sarcoidosis was negative. Histopathology of the lesion showed an abundance of well-circumscribed granulomas composed of plenty of epithelioid cells and histiocytes with a few lymphocytes in the mid-dermis with central caseating necrosis [Figure 2a and b]. Peri-follicular lymphohistiocytic infiltrates were seen and few follicles showed basal layer degeneration with pigment incontinence. Special stains such as Fite-Faraco stain for Mycobacterium tuberculosis and periodic acid–Schiff (PAS) were negative. He was treated with topical tacrolimus 0.03% ointment twice a day application and oral minocycline 45 mg once daily [Figure 3].

Discussion
LMDF was initially described by Tilbury Fox in 1878 as disseminated follicular lupus. It is pre-dominant in young males in their third decade. Prepubertal children and the elderly are rarely affected. Typical skin lesions are multiple discrete, smooth, 1–3 mm, monomorphic, symmetrical...

Figure 1: (a and b) Multiple, discrete pinkish to erythematous monomorphic papules of 1 to 4 mm size, clustered over the left cheek and around the left eye. A few lesions show mild scaling, and the surrounding skin shows hypopigmentation. Similar monomorphic discrete scaly papules are seen clustered over the right cheek, infraorbital region, and a few scattered over the nose

Figure 2: (a) Plenty of well-circumscribed granulomas composed of several epithelioid cells and histiocytes and a few lymphocytes in the mid-dermis with central caseating necrosis. H and E staining at 100x. (b) Caseation necrosis (arrow). H and E at 400x

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reddish-brown or brown-to-yellowish dome-shaped translucent papules and nodules. The centro-facial area is most commonly involved although the lower eyelids, forehead, nasolabial folds, and perioral areas can also be affected.[1] It is a distinct etiology not related to tuberculosis, Demodex mite, acne, or rosacea and hence the recently coined term FIGURE (Facial Idiopathic Granulomas with Regressive Evolution) seems more appropriate.[2] Histopathology shows large epithelioid cell granulomas with caseating necrosis surrounded by a lymphocytic infiltrate and occasional multinucleated giant cells in the dermis.[3] Over the years, anti-tuberculous drugs, tetracycline, isotretinoin, dapsone, clofazimine, corticosteroids, tranilast, metronidazole, and topical tacrolimus have been used either as monotherapy or in combination with variable efficacy. The 1,450-nm diode laser has also been shown to be fairly effective.[4] Other conditions to rule out in such a case are papular sarcoidosis, GR, CGPD, and POD. Sarcoidosis is very rare in children and almost always associated with systemic involvement. Histologically, it is characterized by “naked granulomas.” GR is characterized by a background of erythema, telangiectasia, pustules, flushing, and edema and is commonly seen in the third to fifth decades. CGPD affects mostly black Afro-Caribbean children and the histopathologic hallmark is a dermal granulomatous infiltrate without necrosis, and lesions heal without scarring. POD is seen in children as erythematous papules and pustules centered around the mouth. Histology shows perivascular and perifollicular inflammation of lymphocytes with giant cells and dermal edema. No granulomas are seen on histology.[5]

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**Conflicts of interest**

There are no conflicts of interest.

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