Generalized papular granuloma annulare

Sir,

Granuloma annulare (GA) is a benign, inflammatory dermatosis with no proven etiology. It involves dermis or subcutis in a process characterized by necrobiosis surrounded by lymphohistiocytes. Various morphological forms are described, including localized, generalized, perforating and subcutaneous.[1] Generalized GA (GGA) is a rare variant seen in 8–15% of cases. Multiple skin colored, pink, or violaceous papules coalescing to form annular plaques are the commonest presentation of the GGA, but the distinctive papular morphology in the absence of the plaques is a rare phenomenon for the generalized variety and presents a diagnostic dilemma. We
report this case for the rarity of isolated papular presentation of the disease.

A 75-year-old female presented with multiple skin colored papules over trunk for 6 months associated with moderate pruritus. The lesions started from neck, upper chest and involved trunk, arms and thighs in a span of 4 weeks. Patient had no history of diabetes mellitus, hypertension, or drug ingestion. On examination there were numerous, discrete skin colored papules, 0.5−1 cm in size, over upper chest, abdomen, lateral aspect of arms and thighs in bilaterally symmetrical pattern [Figure 1]. Hair, nail, and mucosae were normal. Laboratory investigations showed severe microcytic hypochromic anemia with hemoglobin - 5.3 gm% (normal: 11−16 mg/dl). Random blood sugar, liver and renal function tests, urinalysis, chest X-ray, fasting lipid profile, antinuclear antibodies, and thyroid profile were normal. Elisa for Human immunodeficiency virus (HIV) 1 and 2 was nonreactive. Histopathological examination from a papule on upper trunk showed palisading granuloma in mid- reticular dermis around focus of mucin and incomplete collagen degradation [Figure 2]. The granuloma consisted of lymphohistiocytes with giant cells forming a semicircular palisade [Figure 3]. Rest of dermis showed perivascular lymphocytic infiltrate. After clinic-pathological correlation, diagnosis of generalized papular GA was made. Most of lesions regressed spontaneously in 4 weeks.

GA is a granulomatous disease characterized by multiple erythematous, annular plaques with histopathological features of necrobiosis and granuloma formation. The etiology of GA is unknown. Mild trauma in form of insect bite, tuberculosis test, or phototherapy is considered a possible triggering factor. Certain viral infections like Epstein Barr, Herpes zoster, and HIV are linked to etiology. Familial cases are also reported. Few drugs have been implicated like gold and allopurinol. It is occasionally symptomatic with variable pruritus and resolves spontaneously. Association with diabetes mellitus is controversial. Reports have suggested an association of GGA with autoimmune thyroiditis and lipid profile abnormalities. GA may represent a paraneoplastic response to certain malignancy like lymphoma. Tendency of GA to remit spontaneously complicates accurate assessment of efficacy of treatment. Various treatment modalities that have been tried include topical steroids, cryosurgery, phototherapy, dapsone, retinoids, cyclosporine, chlorambucil, antimalarials, niacinamide, vitamin E, pentoxifylline, infliximab, topical imiquimod, and calcineurin inhibitors.

Isolated papular morphology of GA in the absence of the typical plaques is a rare presentation and often misleads the physician. Therefore, the diagnosis of papular GA must be considered in such a presentation and confirmed by histopathological examination as it has distinctive histopathological picture of necrobiosis, granuloma formation and mucin deposition.
Recurrence of zosteriform lesions on the contralateral dermatome: A diagnostic dilemma

Sir,

Zosteriform vesicular lesions of the skin could be due to either herpes zoster (caused by varicella zoster virus) or zosteriform herpes simplex (caused by herpes simplex virus). Recurrence of zosteriform vesicular lesions in the contralateral dermatome has been rarely reported, that too, only in immunocompromised individuals. Herein, we report the recurrence of zosteriform vesicular lesions on the contralateral dermatome in an immunocompetent individual.

A 40-year-old man came with the complaints of painful blisters on the left side of his chest wall and the back for the past two days. He also had a history of similar lesions on the corresponding region on the right side of his body four years ago, which was not investigated or treated, and healed spontaneously in 10 days leaving some residual scars. He also gave history of chickenpox at 7 years of age. On examination, grouped vesicles on an erythematous base were seen distributed along the left T4-5 dermatomes, suggestive of herpes zoster or zosteriform herpes simplex. Postinflammatory hypopigmented scars were seen on the right T4 dermatome suggestive of post-zosteriform vesicular lesions sequelae [Figure 1]. His complete blood count was normal. His fasting blood sugar and postprandial blood sugar levels were within normal limits. Tzanck smear from the vesicles showed multinucleated giant cells [Figure 2]. His human immunodeficiency virus - enzyme linked immunosorbent assay (HIV-ELISA) was negative. Viral culture, polymerase chain reaction (PCR), and direct fluorescent antibody staining were not performed.

Figure 1: Grouped vesicles on left T4 and T5 dermatomes and postinflammatory hypopigmented scars on right T4 dermatome

Figure 2: Multinucleate giant cell (Leishman stain, ×100)

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