A 56-year-old male patient presented with a solitary asymptomatic growth over the chin since 3 years [Figure 1]. There was history of trauma to the chin while shaving followed by development of a small raised lesion over the same site. There was history of gradual increase in size of the lesion over a period of 2 years. Dermatological examination showed a solitary well-defined infiltrated skin-colored plaque on the chin. The rest of the face was unaltered. The differential diagnosis included granuloma faciale, collagen nevus, and gnatophyma. Skin biopsy from the lesion on the chin showed sebaceous gland hyperplasia and peri-appendageal lymphohistiocytic infiltration with fibrosis in the dermis [Figure 2a and b]. After confirming the diagnosis of gnatophyma, the patient was posted for surgical excision.

Rosacea is a common disease affecting mostly middle-aged women and is manifested by transient or persistent erythema, telangiectasia, edema, papules, and/or pustules on the face, most typically in the centrofacial area. The etiology is unknown. However, it is postulated that tissue damage, oxidative stress, decreased superoxide dismutase, and production of vasoactive substances such as serotonin, prostaglandins, and substance P are involved in the pathogenesis of rosacea. Other factors known to be involved include opioid peptides, Helicobacter pylori infections, Demodex brevis, and Demodex folliculorum.

Phymas are slowly progressive disfiguring lesions of the face most commonly seen in men over the age of 40 years. They occur due to edema and chronic inflammation resulting in tissue hypertrophy and hyperplasia of sebaceous glands. Rhinophyma is the most common form of phyma affecting nose while other rare sites include chin (gnatophyma), forehead (metophyma), ears (otophyma), and eyelids (blefarophyma). Very few cases of gnatophyma have been reported in the scientific literature.

Histologically, phyma can be divided into two types: the common type, characterized by fibrosis and hyperplasia of sebaceous glands, and the severe form resembling elephantiasis caused by chronic lymphedema. Our patient showed histopathological evidence of fibrosis and hyperplasia of sebaceous glands along with peri-appendageal lymphohistiocytic infiltration, corresponding to the common type.
Possible treatment options available for rosacea include oral antibiotics such as metronidazole, minocycline, doxycycline, clarithromycin, cephalosporins, azelaic acid, permethrin, atenolol, clonidine, ivermectin, oral isotretinoin, and treatment of *H. Pylori*.[2] Oral antibiotics and oral isotretinoin are reported to be effective in reducing the phymas.[1,2] Carbon dioxide laser and surgical excision are other treatment modalities for severe phymas.[4]

**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.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

**References**

1. Crawford GH, Pelle MT, James WD. Rosacea: I. Etiology, pathogenesis, and subtype classification. J Am Acad Dermatol 2004;51:327‑41.
2. Macedo ACL, Sakai FDP, Vasconcelos RCF, Duarte AA. Gnatophyma - a rare form of rosacea. An Bras Dermatol 2012;87:903‑5.
3. Vidigal MR, Kakihera CT, Gatti TRSR, Tebcherani AJ, Pires MC. Gnatophyma: A rare variant of phyma. Clin Exp Dermatol 2008;33:743‑4.
4. Carlson JA, Mazza J, Kircher K, Tran TA. Otophyma: A case report and review of the literature of lymphedema (Elephantiasis) of the ear. Am J Dermatopathol 2008;30:67‑72.