

LETTERS TO THE EDITOR

Micropapular Sarcoidosis

Sir,

Sarcoidosis is a multisystemic disorder of unknown cause. Cutaneous manifestations occurring in 20–35% of patients with systemic sarcoidosis (1). Micropapular sarcoidosis is a rare form of cutaneous sarcoidosis. Characteristics include acute onset and good prognosis without leaving scars (2, 3). Pulmonary involvement is less common than in other forms of cutaneous sarcoidosis; however, ocular disease is relatively frequent (3). Here we describe the first Chinese case of micropapular sarcoidosis with pure cutaneous involvement. The lesions were successfully treated with the systemic steroid.

CASE REPORT

A 26-year-old Chinese man presented with a 2-year history of progressive papular skin lesions which had begun from the back and gradually spread to involve the nuchal area, upper limbs and chest. These papules were asymptomatic. In the past, he had enjoyed good health and was not on medication. No manifestations of fever, night sweating, cough, dyspnea or lymphadenopathy had been noted.

Examination of the skin revealed numerous 1-mm sized, whitish, shiny, non-scaly papules, some with confluence to 2 to 3 mm in diameter, located on the back, nuchal area, upper limbs and chest (Fig. 1). No Koebner phenomenon or tendency of follicle-correspondence was observed. Lymphadenopathy was not found.

Laboratory studies, including haemogram, liver function test, renal function test, serum levels of calcium and alkaline phosphatase, erythrocyte sedimentation rate, VDRL and serum protein electrophoresis were all within normal limits or negative. Lymphocyte subpopulation study showed a normal T4/T8 ratio (T4: 41.3%, T8: 21.7%). The PPD test, read at 48 h, was positive, with an indurated erythema of 1.6 cm in diameter. Study of cell-mediated immunity to multiple recall antigens showed positive results to tetanus and tuberculin antigens but negative to candida, trichophyton, proteus, diphtheria and streptococcus antigens. The Kveim test and test for angiotensin-converting enzyme level were not available. The chest roentgenogram was normal. No hilar lymphadenopathy or lung parenchymal infiltration was found. The ophthalmofunduscopy revealed one greyish lesion over each side of the lower retina. The nature was unknown.

Two biopsy specimens from the papules over the back and right del-



Fig. 1. Numerous whitish, micropapular lesions on the back.

toid region, respectively, revealed a non-caseating granulomatous infiltrate superficially located in the upper dermis. On serial sections, the granulomatous infiltrate did not show a correlation with the hair follicle structure. PAS and acid-fast stains were negative. Polariscopic examination failed to reveal any birefringent materials in the granulomas.

The patient was treated with oral prednisolone, 30 mg per day, for 3 weeks. The dosage was slowly tapered and discontinued in the next 2 months. The therapy produced a good response with cessation of new lesion formation and flattening of old lesions. There was no evidence of recurrence 8 months after treatment.

DISCUSSION

Concerning the numerous, long-standing, asymptomatic, small shiny papules in our patient, four differential diagnoses should be taken into account, i.e. lichen nitidus, generalized papular granuloma annulare, lichen scrofulosorum and micropapular sarcoidosis. The former two conditions can readily be excluded by the histopathologic findings because neither a circumscribed lichenoid infiltrate nor degeneration of collagen was found.

There is difficulty in distinguishing lichen scrofulosorum from micropapular sarcoidosis, both showing superficial dermal non-caseating epithelioid granulomas. However, granulomas of lichen scrofulosorum are usually seen in the vicinity of hair follicles or sweat ducts, usually in children with underlying bone or gland tuberculosis. It is perifollicular and tends to group into plaques. Scaling is a prominent feature. We could distinguish this case from lichen scrofulosorum on the following points: (a) papular lesions were not follicle corresponding and showed no scales, (b) there was no evidence of tuberculosis in our patient; the positive PPD test may be due to previous BCG vaccination, (c) granulomas did not correlate with the hair follicles, (d) a good response to oral corticosteroid therapy was observed.

Although sarcoidosis is a multisystemic disease by definition, cutaneous lesions can be the only manifestation of sarcoidosis in about 25% of the patients with sarcoidosis seen in dermatological clinics.

Micropapular sarcoidosis is quite rare. Fewer than a dozen cases have been reported in the English literature (3, 4–8). Among these, some are described as “lichen nitidus-like sarcoidosis” (4) or “eruptive cutaneous sarcoidosis” (5), and most cases are Caucasians.

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“Zosteriform” Lichen Planus: the Bizarre Consequences of a Misnomer

Sir,

Our dermatological nomenclature does not always reflect reality but, conversely, may sometimes create in our brain a world that does not exist. A bizarre example is “zosteriform lichen planus”, as described by Lutz et al. (1) in two patients with linear lichen planus. Although photographic documentation of one of these cases clearly shows that the arrangement of the disorder is not dermatomal but follows the lines of Blaschko, the mere term “zosteriform” makes the authors believe that the arrangement is indeed zosteriform, and that a search for varicella-zoster virus in the affected skin is a reasonable approach. Other authors similarly fixated with the erroneous term “zosteriform lichen planus” have likewise discussed the possibility of a Köbner phenomenon after herpes zoster infection (2–4).

It should be noted, however, that linear lichen planus virtually never shows a dermatomal arrangement but follows the lines of Blaschko (5). Compared to this disease, cases of true zosteriform lichen planus are extremely rare, and only such exceptional cases may be explained as a Köbner phenomenon induced by a preceding zoster eruption (6).

In conclusion, the arrangement of linear lichen planus is usually non-zosteriform, and the term “zosteriform” should be jettisoned from the description of such cases.

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Reply to the Letter by Happle

Sir,

We appreciate the comments of Dr. Happle. Despite Dr. Happle’s crusade, the term “zosteriform” lichen planus is firmly entrenched in the dermatologic literature and is not likely to disappear promptly. Irregardless of nosology, the unilateral/linear/Blaschko variant of lichen planus does not contain varicella or herpes simplex viral DNA, as our study demonstrated.

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