Granuloma Faciale with Disseminated Extrafacial Lesions

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Abstract

Granuloma faciale (GF) is a rare cutaneous disorder categorized as a localized form of small-vessel vasculitis. Clinically, it manifests as single or multiple well-demarcated red-brown plaques, papules and nodules, nearly always confined to the face. Herein, we report a 39-year-old man with multiple red-brown infiltrated plaques on face and extrafacial lesions on back, shoulders and both arms. Skin biopsy revealed typical histopathological findings of GF. The patient failed to respond to pulsed dye laser but intralesional triamcinolone combined with cryotherapy led to an acceptable response. *(Iran J Dermatol 2009;12: 131-133)*

Keywords: extrafacial granuloma faciale, disseminated granuloma faciale, small-vessel vasculitis

Introduction

Granuloma faciale (GF) is a rare cutaneous disorder categorized as a localized form of small vessel vasculitis. Clinically, it manifests as single or multiple erythematous to livid papules, plaques or nodules usually occurring on the face that are often with follicular accentuation [1]. The lesions are usually asymptomatic but may be associated with mild pruritus. The sites of predilection are the sides of the nose (30%), tip of the nose (7%), preauricular area (22%), cheeks (22%), forehead (15%) and helix of the ear (4%) [2]. Disseminated or extrafacial GF has been reported but is very rare [3-8].

Case Report

A 39-year-old man presented to our clinic with several persistent mildly pruritic plaques over his forehead, shoulders, both arms and back for almost one year. The initial lesion had developed on the back with gradual involvement of the shoulders, arms and at last, the face. He had no significant past medical history.

On examination, there were red-brown, 0.5–3 cm, well-demarcated and slightly indurated non-scaly papules and plaques over the face (Figure 1), back (Figure 2), shoulders and arms. The follicular openings over some lesions were accentuated. (Figure 1). General physical examination was normal.

Routine laboratory tests were unremarkable. A skin biopsy from the latest lesion showed normal epidermis with narrow grenz zone in subepidermal portion associated with infiltration of mixed inflammatory cells, including lymphocytes and many eosinophils and some nuclear dusts around vessels with partially occluded lumens and prominent endothelial cells, thereby confirming the diagnosis of granuloma faciale (Figure 3).

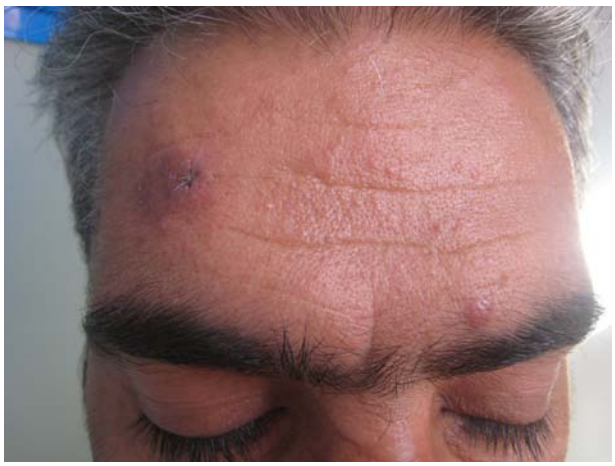

Figure 1. *Facial red-brown papules and plaques*

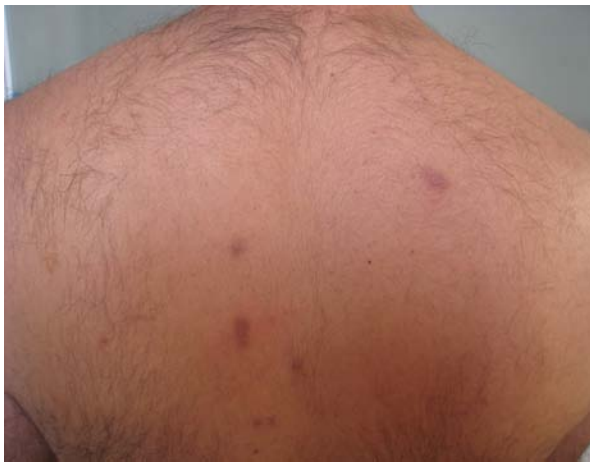

Figure 2. *Disseminated red-brown plaques on the back*

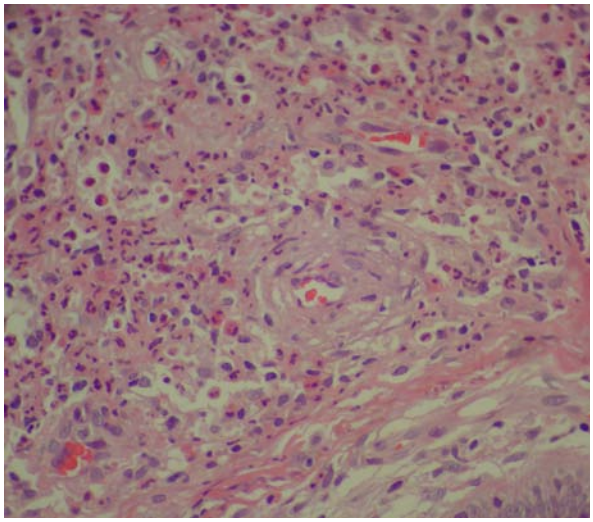

Figure 3. *Infiltration of mixed inflammatory cells, including lymphocytes, some nuclear dusts and many eosinophils around vessels with prominent endothelial cells and fibrinoid necrosis (H&E *40)*

Initially, the patient was treated with pulsed dye laser (585 nm) for two sessions but no response was observed. Then, cryotherapy in combination with intralesional triamcinolone acetonide (5 mg/ml) was tried. This treatment was repeated every 4 weeks for three courses, resulting in an acceptable response.

Discussion

Granoluma faciale is characterized by one to several soft erythematous to livid papules, plaques or nodules with follicular accentuation. It is often a disorder of middle-aged white men, but it can occur at any age and sex [3]. The typical lesion of granuloma faciale is a solitary plaque on the face[4]. Extrafacial involvement is rare and has been reported to involve the back, arms, chest, shoulders and thighs [5-8]. Our case had involvement of the back, shoulders and arms in addition to typical facial lesions. The precedence of extrafacial lesions some months prior to facial ones in our patient was quite striking that has been reported only once before [8].

GF has distinctive clinical characteristics but erythema elevatum diutinum, sarcoidosis, lymphoma, lupus, and basal cell carcinoma are the main differential diagnoses [9].

GF is resistant to treatment. Many different medical therapies, including topical or intralesional corticosteroids, antimalarials [10], dapsone, clofazemin, isoniazid, and topical tacrolimus [11] have been tried with various results. A variety of surgical procedures, such as surgical excision [12], dermabrasion, argon laser, carbon dioxide laser, pulsed dye laser [13], electrosurgery and cryotherapy have also been used for the management of GF. Also, a combination of intralesional corticosteroid and cryotherapy has been reported to be effective [8, 14] which had an acceptable result in our patient.

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