Granuloma faciale

Sir,

A 33-year-old woman presented with multiple asymptomatic reddish-brown soft papules and plaques on her forehead [Figure 1a]. The lesions were few millimeters to 1.8 cm in dimension and associated with perilesional erythema. The lesions had gradually increased in the last one year. There was no history of photosensitivity or joint pains. No skin lesions were present elsewhere. General and systemic examination results were normal. Routine laboratory investigations were normal. Clinical differential diagnoses of sarcoidosis, discoid lupus erythematosus, and Jessner's lymphocytic infiltration of skin were considered.

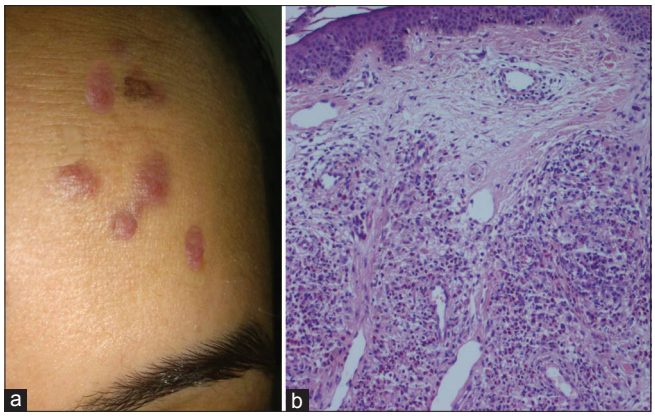

Figure 1: (a) Reddish papulo-plaques on forehead. (b) Photomicrograph of lesion showing Grenz zone and mixed inflammatory infiltrate, (H and E stain ×40)

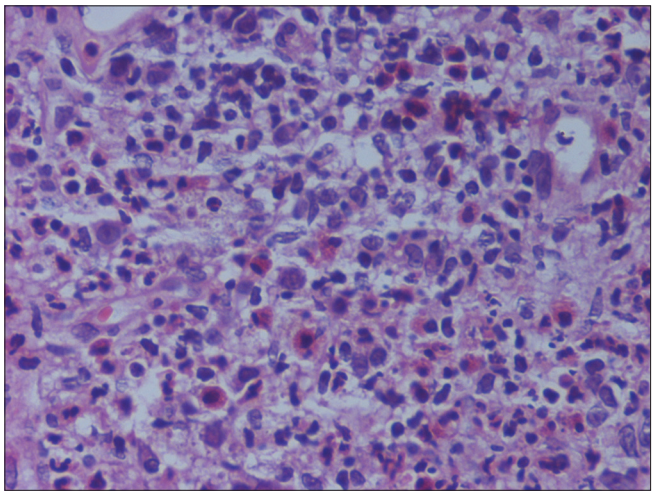

Figure 2: Dermal polymorphous infiltrate with abundance of eosinophils (H and E, ×400)

Histopathology showed a normal epidermis with an underlying subepidermal Grenz zone and a dense mid-dermal polymorphous inflammatory infiltrate [Figure 1b]. The inflammatory infiltrate consisted of lymphohistiocytes, neutrophils, few plasma cells, and many eosinophils [Figure 2]. Scattered neutrophilic nuclear dust was present but no vasculitis was seen. A diagnosis of granuloma faciale (GF) was rendered.

GF is a rare but distinct inflammatory dermatosis characterized by reddish brown to violaceous single or multiple plaques or nodules located primarily on face. It is usually seen in middle-aged adults and has predilection in males. GF may show prominent follicular orifices and may be covered with telangiectasias.[1] The condition is asymptomatic and has no systemic features. Extrafacial presentation has been reported.[2] Sites include scalp, trunk, and extremities. The clinical differential diagnoses include lupus vulgaris, sarcoidosis, discoid lupus erythematosus, pseudolymphoma, Jessner's lymphocytic infiltrate, and angiolymphoid hyperplasia with eosinophilia. The lesions tend to be chronic, slow growing, and persistent.

Microscopic examination is diagnostic and should be performed to exclude other conditions. Skin biopsy shows a subepidermal Grenz zone and a dermal mixed inflammatory infiltrate consisting predominantly neutrophils and eosinophils. A small vessel vasculitis is usually present. Its pathogenesis is unknown but role of proinflammatory cytokines has been implicated. Production of interleukin-5 by clonal T-cell population may cause chemotaxis of eosinophils to the lesion.[3]

It is a recalcitrant condition notorious for its resistance to treatment. Glucocorticoids, dapsone, cryotherapy, laser ablation, and surgery have been used to treat GF in the past. A complication of scarring may result from ablative treatment. Pulsed dye laser often produces resolution without scarring and should be generally tried before putting the patient on long-term medication. Topical tacrolimus, which inhibits T-lymphocyte proliferation and hence release of cytokines has been reported to be successful in treating GF including extrafacial GF and seems to be the best medical treatment currently available.[2]

This patient was treated with topical application of tacrolimus ointment 0.1% twice daily for 8 weeks. At 6 months followup the lesions had significantly diminished and no relapse had occurred.

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Conflicts of interest

There are no conflicts of interest.

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