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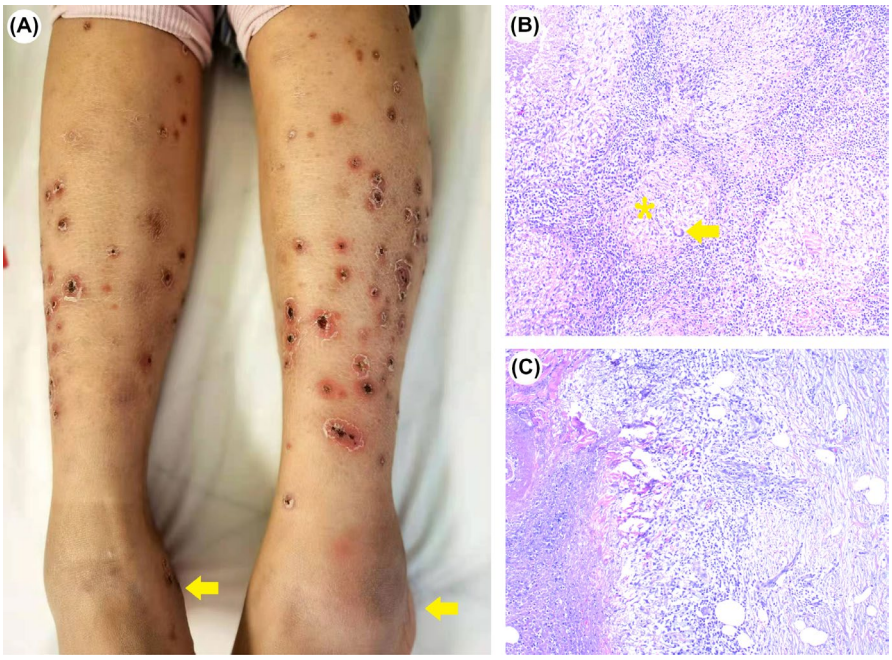
Clinical Images: Papulonecrotic tuberculid and Poncet disease



The patient, a 27-year-old woman, presented with a 1-month history of swelling and tenderness of bilateral ankle joints (**A**, arrows). Three months ago, she received topical steroids for treating widespread papules and pustules on her lower legs that emerged after an episode of high-grade fever (**A**). She had no cough, low-grade fever, or weight loss. Physical examination detected enlarged submandibular lymph node (4 cm × 3 cm) with poor mobility without tenderness. Complete blood count, liver function tests, antinuclear antibody, and tests for syphilis, human immunodeficiency virus, human cytomegalovirus, and Epstein-Barr virus were all normal, as were her chest radiography findings. Her erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) level were elevated (ESR 67 mm/h, reference range <26 mm/h; CRP 27 mg/l, reference range <3 mg/l). The interferon-γ release assay specific for the *Mycobacterium tuberculosis* was positive (6.13 IU/ml, reference range < 0.35 IU/ml). Histologic analysis of the submandibular lymph node showed epithelioid granulomatous lesions (asterisk) with massive caseous necrosis and tuberculoi nodule formation (arrow) (**B**), and histologic analysis of the skin of the left lower limb showed necrosis and lymphocyte infiltration (**C**). On the basis of these findings, the diagnoses of papulonecrotic tuberculid (PNT) and Poncet disease (PD) were made. Extrapulmonary tuberculosis constitutes approximately 10% of all cases of tuberculosis and cutaneous tuberculosis makes up only a small proportion of these cases (1). Tuberculids represent the paucibacillary end of the spectrum, in which the skin lesions are considered to be induced by hypersensitivity reaction to the mycobacterial antigens lodged in cutaneous blood vessels, and mainly consist of PNTs, including penile tuberculids, erythema induratums of Bazin, and lichen scrofulosorums (2). Because of perplexing and diversifying clinical presentations, diagnosis of cutaneous tuberculosis can pose a great challenge for dermatologists in daily practice. Interestingly, the PNT was speculated to be associated with Takayasu arteritis (3). In addition to PNT, PD is also a rare, immune-mediated, paucibacillary manifestation of tuberculous infection. It may induce a sterile, presumably reactive arthritis (4). Likewise, the diagnosis of PD can be sometimes difficult for the rheumatologists, especially when etiology is lacking.

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