



LUPUS VULGARIS- FOREHEAD PRESENTATION IN INDIAN SUBSET

Dermatology

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ABSTRACT

INTRODUCTION: Cutaneous tuberculosis constitutes up to a quarter of cases of overall tuberculosis. Lupus vulgaris is that the commonest sort of cutaneous tuberculosis (59%). Incidence of infection is more common in women than men. In India, extremities and buttocks are more susceptible to lupus vulgaris than the face. **CASE PRESENTATION:** A 49-year-old female presented with a 10-year-old history of the red raised lesion over the forehead. She was initially treated for Psoriasis with corticosteroids and mentioned our Department. Full workup of the patient was done including Mantoux which was positive. Skin biopsy was an implicational granulomatous disease. **CONCLUSION:** The lesion was resolved with ATT. Thus, in developing countries where tuberculosis is prevalent, cutaneous Tuberculosis is a crucial medical diagnosis with similar presentation.

KEYWORDS

Cutaneous Tuberculosis, Lupus Vulgaris

INTRODUCTION

Tuberculosis remains one among the prevalent diseases in developing countries. Cutaneous Tuberculosis constitutes up to a quarter of all the TB cases [1]. Transmission by ingestion or inoculation can occur. Cutaneous tuberculosis occurs when there's an opportunity within the mucocutaneous barrier, facilitating the entry of the organism. Lupus vulgaris and Scrofuloderma are more prevalent in women, whereas men are more related to tuberculosis cutis verrucosa and ulcerative tuberculosis [1]. lupus vulgaris may be a chronic progressive sort of cutaneous tuberculosis initially appearing as a solitary, small, reddish-brown, flat plaque of sentimental gelatinous consistency which may reach become infiltrated and brown, occurring in previously sensitized individuals, or as a complication of BCG vaccination [2]. It shows a characteristic "apple jelly" nodule appearance on diascopy. Among the Indian subset, it's a high incidence on thighs, buttocks and legs, whereas face may be a common site of involvement within the European subset [3, 4, and 5]. Here we are reporting a case of an Indian female presenting with lupus vulgaris on the forehead with no history suggesting endogenous source or primary inoculation.

CASE REPORT

A 49-year-old female patient presented to our Dermatology OPD with itchy, red raised lesion over the proper side of the forehead, above the eyebrow for 10 years. She initially noticed a little pin-point lesion which had a gradual onset and progressed over the past 5 years [Figure No.1]. The patient had a history of photosensitivity. When the patient had her first dermatology consultation, her initial presentation alongside the history of native medication was implicational Irritant dermatitis secondary to Psoriasis. A course of topical corticosteroids was then started which was ineffective, thus presenting the patient to our OPD. There was no history of implicational trauma or tuberculosis infection within the family.



Figure No. 1. Patient Had a History Of Photosensitivity

Cutaneous examination revealed single, erythematous plaque with well-defined borders and central atrophy of gelatinous consistency over the proper side of the forehead with no scaling or discharge. The lesion was non-tender, and Diascopy revealed apple jelly nodule appearance [Figure No. 2]. No lymphadenopathy was present. Systemic examination was normal.

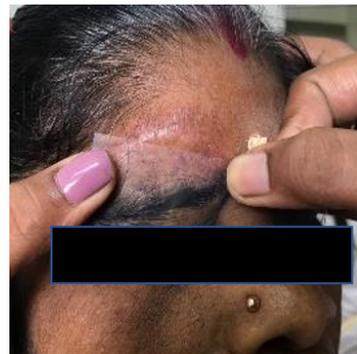


Figure No. 2. No Lymphadenopathy Was Present.

Complete blood count, renal function tests, liver function tests were within normal limits. KOH scraping was negative, HIV I & II was non-reactive, slit skin smear was negative whereas Mantoux was 22 mm positive. Chest X-Ray was normal.

Figure no. 3. A skin biopsy showed tissue lined with squamous epithelium with sub-epithelium showing granulomatous inflammation composed of epitheloid histiocytes and nucleated Langerhan's type giant cells, surrounded by lymphocytes and foci of necrosis implicational lupus vulgaris.

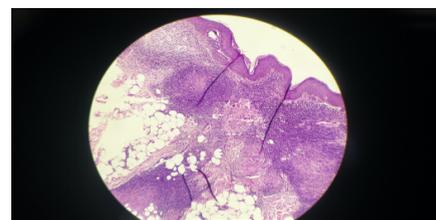


Figure No. 3. Epitheloid Histiocytes and Nucleated Langerhan's Type Giant Cells

She was explained about the condition and was mentioned Government Hospital where she was started on Category I antitubercular drugs under RNTCP. Patient came for follow up at 3rd and 5th weeks' post-treatment initiation and therefore the lesion seemed to fade.

DISCUSSION

Lupus vulgaris, a clinical sort of cutaneous tuberculosis is seen in individuals who had a history of tuberculosis and high tuberculin sensitivity [1]. It's one among the foremost prevalent sorts of cutaneous tuberculosis. It arises either by contiguous extension of the disease from the underlying affected tissue or haematogenous or lymphatic spread from an underlying focus. It is often a reactivation of a latent cutaneous focus secondary to previous silent bacteraemia or also can arise after exogenous inoculation or as a complication of BCG vaccination [1, 5, 6, and 7]. Concerning the bacterial load, TB is assessed into Paucibacillary (Tuberculosis Verrucosa Cutis & Lupus Vulgaris) and Multibacillary (Primary inoculation TB, Tuberculosis chancre, Scrofuloderma etc)[3].

The disease may have different sorts of presentation like plaque, ulcer, mutilating, vegetative lesions, tumour-like and papulonodular lesions. The plaque sort of lesions shows a peripheral extension to become gyrate or discoid in shape with areas of atrophy [2,5]. Histologically, the presence of tubercles is characteristic of lupus whereas caseation may or might not be present [7].

Diagnosis of cutaneous Tuberculosis is difficult because the clinical picture is confusing and thus, investigations are needed [8]. Within the present case scenario, AFB couldn't be demonstrated. The Mantoux test is positive in lupus vulgaris as in present case but negative Mantoux doesn't rule out TB. TB may be a granulomatous reaction and granuloma usually shows central caseous necrosis whereas in our case there was no evidence of caseous necrosis. Whereas, when the patient was administered ATT, it had been responsive towards the treatment. Thus, a therapeutic trial of ATT is justified even when histology is inconclusive. Diagnosis is often done even supported response to the ATT given.

CONCLUSION

Lupus Vulgaris though not a standard diagnosis for lesions presenting on the forehead, it should be considered together of the differentials for long-standing erythematous annular plaques with central atrophy, regardless of the location of the lesion.

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