INFLAMMATORY SKIN DISEASES (OTHER THAN ATOPIC DERMATITIS & PSORIASIS)

GRANULOMATOUS DERMATITIS: A DIAGNOSTIC CHALLENGE

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Background: Granulomatous dermatitis presents a diagnostic challenge because an identical histologic picture is produced by several causes.We,herein,report two cases with GD challenge.

Observation: A 51-year-old female presented with erythematous and infiltrated plaques over her thorax and upper limbs.Cutaneous biopsy (CB) showed caseating epithelioid cell granulomas.The chest CT scan showed symmetric mediastinal adenomegaly with interstitial involvement.She received antitubercular treatment and cutaneous lesions disappeared.Six months later,she presented with the same cutaneous lesions.CB showed sarcoidal granulomas in upper dermis.The tuberculin anergy,the negative QuantiFERON®-TB test,the Immunophenotype of Bronchoalveolar lavage Lymphocyte were consistent with sarcoidosis.She received corticosteroids with resolution of skin lesions and pulmonary impairment.
A 42 year-old female presented in 2012 with a 3-year history of two plaques with annular pattern on the neck and groin,measuring 8 cm.The borders were brownish with elevated soft skin surface.CB revealed epithelioid granuloma,with minimal caseation.The culture of the CB was positive to M.bovis.She received HRZE for two Months then HR for seven months with therapeutic failure.She received after that HR and oflocet for 2 months and cutaneous lesions disappeared.She presented in december 2017 with the same lesions and CB found non-caseating granulomas.PCR was positive to M.Bovis.

Key message: Cutaneous tuberculosis forms an important differential diagnosis of epithelioid cell granulomas.Absence of caseation doesn't rule out tuberculosis.Tuberculosis and sarcoidosis can occur in the same patient rarely.Infective agents including Mycobacteria are likely triggers in a genetically predisposed individual and this initial event leads to the sarcoidal granulomatous response.Cutaneous tuberculosis caused by M.bovis is rare.The long-term asymptomatic reactivation of disease has been previously observed.Treatment usually consists of rifampicin, isoniazid and ethambutol.Treatment duration is generally extended to 9 months due to the exclusion of pyrazinamide,since all strains of M. bovis are resistant to it.Fluoroquinolones were used only for a small number of

patients,preventing us from estimating results with these agents.