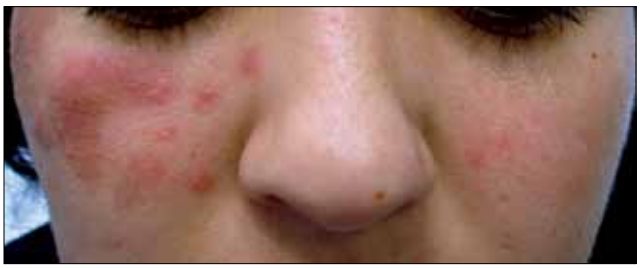
Answer to Dermacase *continued from* ***page 319***

2. Granuloma faciale



First reported by Wigley in 1945,[1] granuloma faciale (GF) is an uncommon, idiopathic, and benign chronic disorder that typically presents as an asymptomatic, persistent condition involving 1 or more smooth erythematous to violaceous papules or plaques. In most cases, it occurs on the faces of middle-aged white men.[1-3] Rarely, there is involvement in other areas in addition to the face, such as the scalp, trunk, or extremities.[2-4] Histology results usually reveal a dense, dermal, nodular, and diffuse mixed inflammatory cell infiltrate composed of lymphocytes, neutrophils, plasma cells, and eosinophils, with sparing of the upper papillary dermis (forming a grenz zone).[2,3] Early lesions might also show characteristics of leukocytoclastic vasculitis.[2,3] A biopsy of one of the cheek lesions in our patient revealed similar findings, with the exception of vasculitic changes.

The cause and pathogenesis of GF is not clear. It has not been associated with any systemic disease. A role for immune complexes and classification of GF under cutaneous vasculitidies have been suggested given immunofluorescence studies demonstrating immunoglobulin (Ig) G, IgA, IgM, and complement C3 deposition within blood vessel walls; however, vasculitic changes might be absent in many cases.[2,3]

Differential diagnosis

Clinical differential diagnosis of GF should include rosacea, lupus erythematosus, and sarcoidosis.[2-7] Rosacea is usually characterized by the presence of central facial erythema, telangiectasia, papules, and pustules, usually in association with a history of flushing upon exposure to heat; occasionally, blepharitis might be observed.[5] Malar erythema, fine scaling, follicular plugging, pigmentary changes, and photosensitivity favour the diagnosis of lupus erythematosus.[6] Common cutaneous manifestations of sarcoidosis, a systemic idiopathic granulomatous disorder, include erythema nodosum and red to violaceous papules and plaques over the face, trunk, and extremities.[7] Histology results for sarcoidosis commonly show noncaseating epithelioid granulomas.[7] In difficult cases, histologic examination of the involved skin might be required to make the distinction among the various possible diagnoses.

Management

Treatment can be difficult, as GF is usually resistant to therapy. Potent or intralesional glucocorticoids are usually used as first-line therapy.[2-4] Other treatment options, including tacrolimus, dapsone, laser ablation, and potentially scarring physical methods (eg, surgical excision, cryotherapy, or dermabrasion), have been documented as beneficial in anecdotal case reports.[2-4,8] Our patient was treated with a potent topical steroid, and experienced almost complete resolution within 3 weeks.

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Competing interests
None declared

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