

Lupus Miliaris Disseminatus Faciei Without Facial Involvement

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Sir,

Lupus miliaris disseminatus faciei (LMDF) is a papular eruption characterized by discrete red-brown, dome-shaped papules on the medial and lateral areas of the face, which often extends onto the neck and chin (1). Extra-facial manifestations are not uncommon and may affect the axilla, shoulders, arms, hands, groins and legs. There has been a previous report of concurrent involvement of the face, neck and chest (2). However LMDF occurring on the neck and chest without facial involvement has not been reported previously. We report here a rare case of LMDF on the neck and chest of a patient without any facial manifestations.

CASE REPORT

A 63-year-old woman presented with a 5-month history of skin lesions on her neck and upper chest. Physical examination revealed symmetrically distributed erythematous macules and papules 3–5 mm in diameter on her neck and upper chest (Fig. 1). The patient was in good health and had no significant past medical history. She was not taking any medication. A skin biopsy showed well-defined nodular inflammatory infiltrates in the dermis (Fig. 2a). These contained epithelioid cells, giant cells, partial central caseation and peripherally located lymphocytes (Fig. 2b). Chest X-ray results were within normal limits and a skin tuberculin test was negative. The combined clinical and histological appearances were considered to be those of LMDF. The skin lesions worsened despite treatment with minocycline and doxycycline.

DISCUSSION

LMDF was first described in 1903 as an eruption consisting of groups of discrete dull red-brown papules tending to form pustules with spontaneous involution over several weeks, leaving pigmented scars (3). Originally, LMDF was considered to be a variant of lupus vulgaris or a tuberculid, since the histological features show granulomatous-type inflammation and caseation necrosis. However, there has been no evidence to date supporting a link with tuberculosis (4). Therefore, acne agminata and facial idiopathic granuloma with regressive evolution have replaced the term LMDF in some parts of the world. However, this condition is not a variant of acne and does not always occur as a clustered lesion, so the term acne agminata does not seem appropriate either. The recently proposed acronym of facial idiopathic granulomas with regressive evolution (FIGURE), is perhaps more appropriate as it avoids linking the condition with acne or tuberculosis (5). However, we consider LMDF to be appropriate terminology for this condition for the present, since the terms acne agminata and FIGURE are used in limited areas of the world. Even though LMDF is not an ideal term for this condition, it is currently the most widely used and accepted term worldwide. The pathogenesis of LMDF remains controversial. Most recently LMDF has been associated with granulomatous-type rosacea, supported by the observation that the granuloma in LMDF appear in association with the pilosebaceous units, and epithelioid granulomas have been found in some patients with rosacea (6). However, the clinical features differ. LMDF

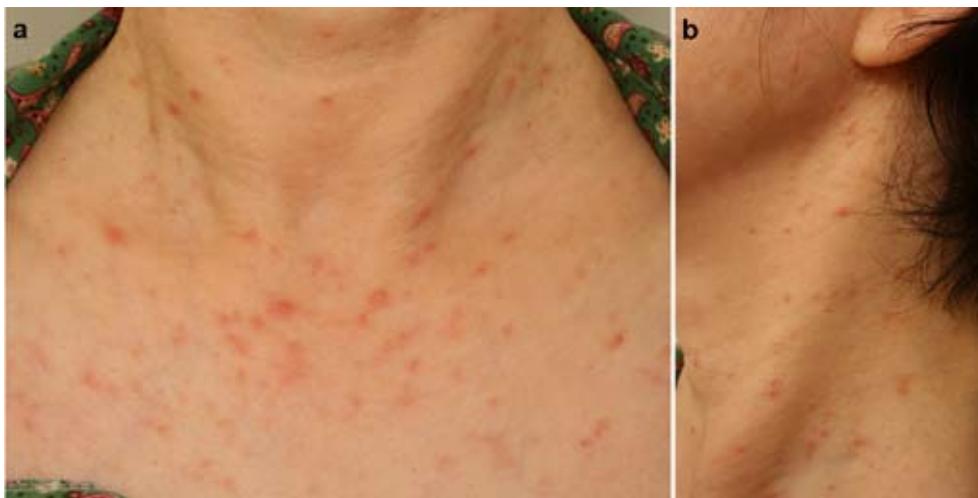


Fig. 1. A 63-year-old woman presented with multiple erythematous macules and papules on her (a) upper chest and (b) neck.

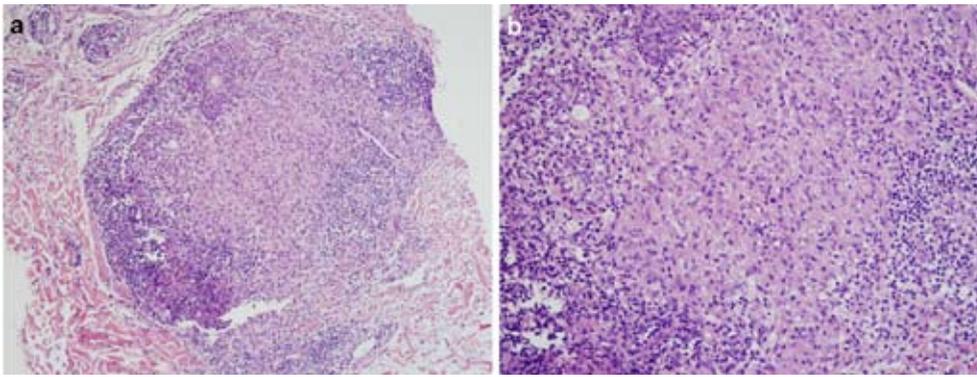


Fig. 2. (a) Large caseation necrosis surrounded by granulomatous inflammation in the dermis. (b) Granulomatous inflammation containing lymphocytes, macrophages and giant cells with central caseation (haematoxylin and eosin (H&E) staining: (a) $\times 100$; (b) $\times 200$).

is not worsened by alcohol or ingestion of spicy food or exposure to sunlight. Moreover, erythema, telangiectasia and pustules are absent. Lastly, rosacea shows no tendency to spontaneous regression. Some authors have suggested that granulomatous rosacea and sarcoidosis present each end of the same disease spectrum and that LMDF is part of this spectrum (2). Although there have been many suggestions about the mode of pathogenesis of LMDF, this remains unknown.

Clinically, LMDF occurs most commonly on the medial and lateral areas of the face, and often extends onto the neck and chin. Extrafacial manifestations are not uncommon. However, extrafacial LMDF is almost always accompanied by facial lesions. Therefore reports of extrafacial LMDF without facial involvement are extremely rare and there has been only one previous report to date, which occurred exclusively on the axilla (7). As far as we know, there has been no report of LMDF exclusively involving the neck and chest, and this is the first reported case so far. Clinicians should bear in mind that LMDF can occur anywhere on the body with no concurrent involvement of the face.

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