Case 1

History

- 82-year-old man, h/o atrial fibrillation, o/w healthy
- Facial rash x 10+ years, ~ June, 2008
- Professor Emeritus of History
- Extensive travel for pleasure – South Africa, Turkey, Belize before 2008; since then, Uruguay, Chile, Argentina, Paraguay, New Zealand
- Two biopsies in the past

Prior biopsy

Photomicrograph courtesy of Nathaniel Smith, MD
Which diagnosis do you favor?

a. Foreign body reaction
b. Granulomatous drug reaction
c. Infectious disease
d. Rosacea, granulomatous
e. Sarcoidosis
f. Other

Further history

• The patient had been treated since 2008 as sarcoidosis
• No known systemic involvement
• Treatments:
  • Methotrexate x 1-2 years – he stopped it as he got pneumonia
  • Doxycycline and intralesional Kenalog qmonth x 7+ years

Diagnosis?

• 2 biopsies, one from 2008 and one from 2017
  • Both tuberculoid granulomas
• I favored granulomatous rosacea
• Stopped ILK, continued doxycycline
• Added Protopic ointment

Photomicrograph courtesy of Nathaniel Smith, MD

GMS, AFB, Fite (no organisms) Polarization negative

Photomicrograph courtesy of Nathaniel Smith, MD
What is the cause of this reaction?

a. Allergic contact dermatitis  
b. Drug reaction  
c. Exacerbation of sarcoidosis after stopping ILK  
d. Natural course of rosacea  
e. Superimposed infection  
f. Other

Drug reaction

Rosacea (Morbihan disease; solid facial edema)

June, 2018: drug reaction or exacerbation of rosacea?

Antille C et al, Arch Dermatol 2004;140:457

August, 2018 — After 1 month of Accutane and no Protopic x 2 months

March 2019 — Stopped Accutane in January, 2019  
a little worse
What stain can be used to highlight Leishmania?

a. CD1a  
b. c-kit  
c. silver  
d. trichrome  
e. von Gieson
“Lupoid” leishmaniasis

- Spread of more typical crusted ulcers or plaques onto cheeks, often as smoother red dermal plaques +/- edema
- 16/254 (~6%) cases of Leishmaniasis in one series

Leishmaniasis – teaching points

- Lupoid variant can present with swelling/redness of cheeks
- Granulomatous patterns are possible – > 30% in one series...
- CD1a (clone MTB1) can be used to highlight the organisms, but they may be undetectable, esp. for New World strains

Case 2

71-year-old woman
4-month history of facial darkening

No new topicals
After it started, began using make-up and a mask (vinaigrette, horseradish, lemon, honey)

PMH: HTN, hyperlipidemia, DM2, seasonal allergies
Medications: aspirin, diltiazem, fluticasone, furosemide, hydrochlorothiazide, losartan, pravastatin, spironolactone
What is your diagnosis?

a. Allergic contact dermatitis  
b. Drug reaction  
c. Lichen planus actinicus  
d. Ochronosis  
e. Postinflammatory hyperpigmentation

Diltiazem-associated photodistributed hyperpigmentation

- Typically in African American patients > other ethnicities (4:1)  
- Women > men (3:1)  
- Photodistributed: face/neck > chest/forearms  
- Pigment may be brown to blue to black  
- Macules or patches, may be reticulated with follicular accentuation of pigment

Differential diagnosis

- Active interface change –  
  • Rules out postinflammatory hyperpigmentation  
  • Could consider lichen planus actinicus or connective tissue disorder

- Clinical –  
  • Sudden, new onset  
  • Follow-up...

Drug-associated facial pigmentation

Diltiazem
- Brown color  
- May be reticulated  
- May have follicular accentuation of pigment  
- Interface change, pigment incontinence, Fontana+

Minocycline, amiodarone, tricyclics, phenothiazines
- Bluish-gray color  
- Perivascular pigment, Fontana+  
- Amiodarone – orange-tinged deposits  
- Phenothiazines and Tricyclics – golden to brown-black deposits
Leishmaniasis
There is a lupoid variant
Histopathology may be tuberculoid or sarcoidal granulomas
CD1a staining may help

Diltiazem-associated photodistributed pigmentation
Consider for new-onset dark pigment on face in darker-skinned patient
Histopathology: interface dermatitis

Take-home points