Unusual Presentation of Scrofuloderma in an Immunocompetent Patient

Sir,

Cutaneous tuberculosis has many faces; from paucibacillary tuberculosis verrucosa cutis to multibacillary acute miliary tuberculosis. Scrofuloderma also called as tuberculosis colliquativa cutis is the second most common type of cutaneous tuberculosis following lupus vulgaris. It is characterized by a bluish-red nodule overlying an infected lymph gland, bone or joint that breaks down to form an undermined ulcer with a granulating tissue at the base. Unusual site and atypical morphological appearance can confuse this entity with other clinically mimicking conditions.

A twenty-eight-years old, otherwise, healthy male, presented with multiple erythematous papules and nodules on his left cheek persisting for the last 8 months. There was history of on and off seropurulent discharge. There was no history of similar complaints in the family or contact with tubercular patient. There was no history of past treatment for these complaints. Cutaneous examination revealed seven ill to well defined papules and nodules coalesced to form a plaque over left cheek. Few lesions had puckered scaring (Figure 1a). No lesions were present over the mucosal side. Submandibular lymph nodes were significantly enlarged; non tender, matted with freely mobile skin over the nodes. Patient was investigated with the differential diagnosis of cervicofacial actinomycosis, scrofuloderma, non tubercular mycobacterium infection, nocardiosis, leprosy and botryomycosis.

Erythrocyte sedimentation rate was 35 mm 1st hour, and Mantoux reading was 15 mm at 72 hours. Ziehl Neelsen stain and culture for acid fast bacilli were non contributory, absence of microorganism on gram stain and pus culture ruled out other bacterial infections. HIV screening was negative. Skiagram of chest as well as of face for underlying bone involvement was normal. PCR was positive for Mycobacterial tuberculosis. Histopathological examination showed atrophied epidermis, epithelioid granuloma containing Langerhans giant cells surrounded by lymphocytes that scotched the doubts and confirmed the diagnosis of scrofuloderma (Figure 2a and b). The patient was started on antitubercular drugs (isoniazid, rifampicin, ethambutol and pyrazinamide). Complete regression of the lesion was seen after 6 months of therapy (Figure 1b).

In the present case, morphology of plaque and site involved suggested cervico facial actinomycoses as first clinical possibility. The absence of sulphur granules and negative culture report for actinomycetes helped us to delineate this condition. Nocardiosis was also ruled out on the basis of absence of gram-positive branched-filaments. Leprosy was marked out on the basis of clinical presentation and biopsy findings. Botryomycosis is a chronic inflammatory condition due to a bacterial infection. The condition was ruled out on the basis of absence of bacteria from pus or biopsy specimen. Histopathological finding, significantly positive Mantoux test, positive PCR for Mycobacterial tuberculosis and complete resolution of lesions with anti tubercular drugs confirmed the diagnosis.

To conclude, this case is being reported for the unusual site and atypical presentation of scrofuloderma in an immunocompetent individual.

REFERENCES
Letter to the editor

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