



## Scientific Letters

### Isolated Cutaneous Sarcoidosis<sup>☆</sup>



#### Sarcoidosis cutánea aislada

To the Editor,

Sarcoidosis is a systemic disease that can involve almost any organ system. Infiltration with non-caseating granulomas is the hallmark of the disease. Cutaneous involvement occurs in 20%–35% of patients with systemic sarcoidosis. It is more commonly observed in young and middle-aged individuals who present with acute onset sarcoidosis characterized by erythema nodosum, associated with bilateral hilar lymphadenopathy and polyarthralgia or polyarthritis.<sup>1</sup> However, isolated cutaneous lesions in the absence of systemic involvement may occur in the context of chronic sarcoidosis.<sup>2</sup> This report describes a case of isolated cutaneous sarcoidosis (CS).

A 48-year-old female non-smoker was admitted to our clinic with diffuse papules on the face and plaques on the upper limbs (Fig. 1). These lesions began 3 years ago as small red papules on the limbs then grew with time. Serum angiotensin-converting enzyme (ACE) level was 8.1 µg/l (reference range: 8.0–52.0 µg/l); hemoglobin: 10.1 g/l; erythrocyte sedimentation rate (ESR): 45 mm/h; and serum calcium: 9 mg/dl (reference range: 8.8–10.89 mg/dl). Chest X-ray was normal. Histopathological analysis of skin punch biopsy showed non-caseating granulomas. A diagnosis of sarcoidosis was made on the basis of these findings.

Treatment with 40 mg methylprednisolone was started with gradual dose reduction to 16 mg. Marked improvement occurred, especially in the skin lesions on the face, but little improvement was achieved in the plaques on the limbs.

Sarcoidosis occurs most commonly in patients between 20 and 40 years of age, and is more prevalent in females. Exclusive cutaneous involvement is rare, and is reported in only about 4%–5% of sarcoidosis patients.<sup>3</sup> It may be mild or severe, self-limiting or chronic, with limited or wide-ranging involvement. The clinical manifestations of skin sarcoidosis vary widely, and include maculopapular lesions of various sizes, changes in old scars, lupus pernio, plaque formation, subcutaneous lesions, etc.<sup>4</sup>

Increased ESR, anemia, leukopenia and hypercalcemia are the common laboratory abnormalities: our patient presented an elevated ESR and anemia. Serum ACE levels are found to be elevated in only 50% of cases, so this parameter is not a very reliable indicator of CS. The ACE level was normal in our patient.

CS with multisystemic involvement is treated with topical steroids or systemic corticosteroids.<sup>5</sup> Asymptomatic patients with isolated lesions may not need systemic corticosteroids, but should continue to be monitored.

Isolated CS is a rare presentation, the diagnosis of which is likely to be missed. Skin biopsy must be performed for a definitive diagnosis of sarcoidosis.

#### Conflict of Interest

None.

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Fig. 1. Diffuse plaques on the upper extremities.

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