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Quick Response Code:

Clinical Image

Osseous sarcoidosis with lupus pernio

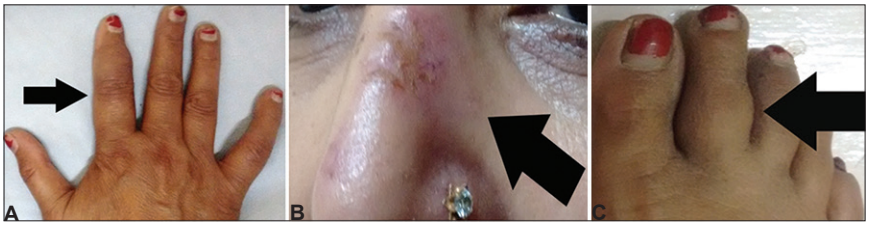

Fig. 1. (**A**) Photograph of the hand showing dactylitis of the right index finger (black arrow). (**B**) Violaceous indurated plaque on the bridge of nose (black arrow). (**C**) Dactylitis of the right second toe (black arrow).

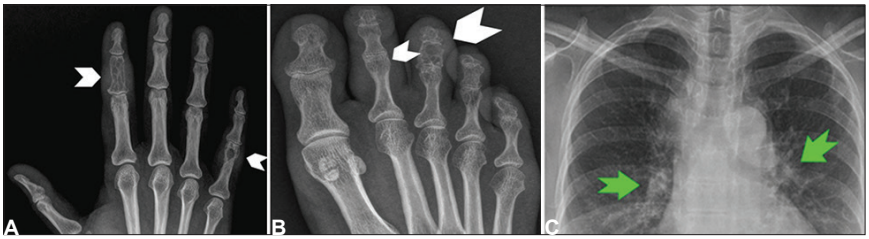

Fig. 2. (**A**) X-ray of the right hand showing osteolytic lesions in the involved phalanges with a reticular pattern (white arrowheads). (**B**) X-ray of the right foot showing osteolytic lesions in the involved phalanges (white arrowheads). (**C**) X-ray chest with bilateral hilar lymph node enlargement (green arrows).

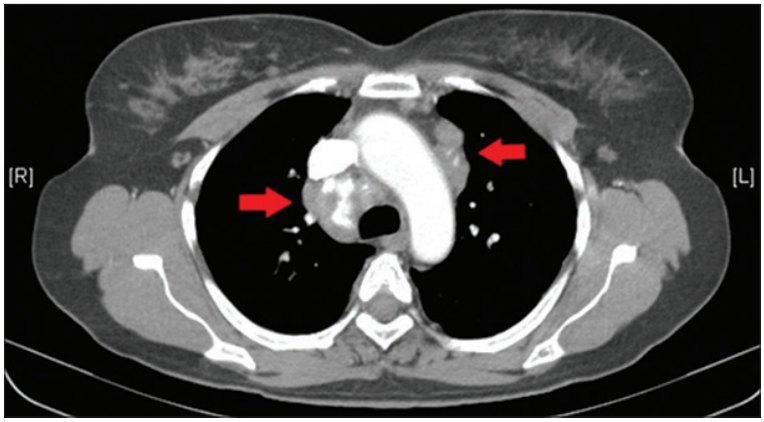

Fig. 3. Computed tomography scan of the thorax showing bilateral mediastinal lymphadenopathy (red arrows), including calcified lymph nodes on the right.

A 60 yr old woman presented to the department of General Medicine, Christian Medical College and Hospital, Vellore, India, in April, 2016 with an 18-month history of purple discolouration and painless swelling of the right index finger, right second toe and bridge of nose. Physical examination revealed a violaceous indurated plaque on the bridge of nose, along with dactylitis of the involved digits, with no fingernail changes (Fig. 1A-C). Radiographs showed osteolytic lesions in the phalanges with a reticular pattern (Fig. 2A, B) and hilar lymph node enlargement (Fig. 2C). Serum angiotensin-converting enzyme levels were elevated (69 U/l, normal 8-52 U/l) while thoracoabdominal computed tomography scan showed mediastinal, hilar and abdominal lymphadenopathy (Fig. 3). There was no clinical or laboratory

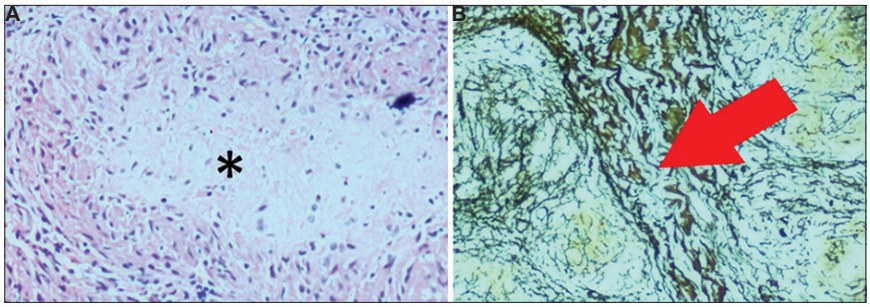

Fig. 4. (**A**) Bone biopsy demonstrating granulomas, marked asterisk (*) (H & E, ×20). (**B**) Skin biopsy demonstrating non-necrotizing granulomas (red arrow) reticulin stain, ×10.

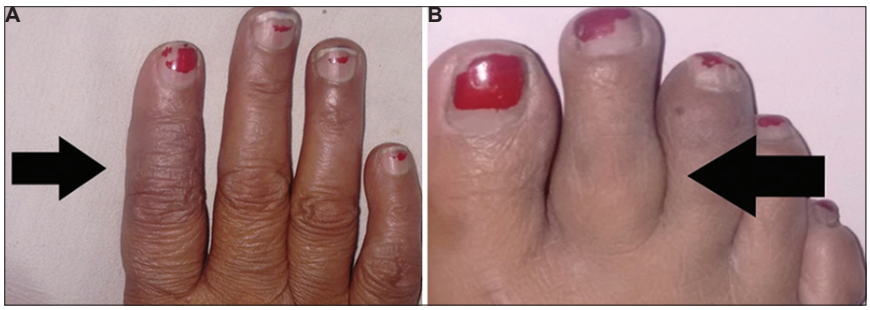

Fig. 5. (**A**) Hand lesion demonstrating partial resolution after 4 days of therapy (black arrow). (**B**) Right foot lesion demonstrating partial resolution after 4 days of therapy (black arrow).

evidence of multiple myeloma. Biopsy from the skin and bone lesions showed non-necrotizing granulomas containing giant cells, with no evidence of mycobacterial or fungal infection (Fig. 4A, B). A diagnosis of lupus pernio with osseous sarcoidosis was made. The patient was treated with prednisolone (1 mg/kg) for two weeks with tapering to 10 mg/day over six weeks, hydroxychloroquine (400 mg/day) and topical mometasone ointment for two months. At follow up after four days, the lesions demonstrated partial resolution (Fig. 5A, B).

Osseous sarcoidosis occurs usually in patients with multivisceral involvement and has a predilection for small bones of the hand and feet. Skeletal lesions are often associated with cutaneous manifestations, most commonly lupus pernio, as in this patient. Differentials such as skeletal metastases, multiple myeloma and chronic osteomyelitis should be considered and ruled out before the treatment. Non-steroidal anti-inflammatory drugs, corticosteroids and hydroxychloroquine are the mainstay of therapy.

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