

# Sarcoidosis Presenting as Telangiectatic Macules

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## PRACTICE POINTS

- Cutaneous manifestations of sarcoidosis can encompass numerous morphologies. A high degree of suspicion should be maintained for any uncertain dermatologic presentation.
- Although papular eruptions are the most common cutaneous findings in sarcoidosis, this case report illustrates a less common vascular-appearing presentation.
- A systemic workup is indicated in any presentation of sarcoidosis.

To the Editor:

Sarcoidosis is a multisystem, noncaseating, granulomatous disorder thought to occur from a combination of immunologic, genetic, and environmental factors.<sup>1</sup> Often referred to as the “great imitator,” the cutaneous manifestations of sarcoidosis encompass many morphologies, including papules, plaques, nodules, and scars.<sup>1</sup> We report an unusual case of sarcoidosis presenting as telangiectatic macules on the lower extremities.

A woman in her early 30s presented with a burning, pruritic, erythematous, telangiectatic eruption on the lower extremities with concurrent ankle swelling of 4 weeks’ duration. The patient denied any fevers, chills, recent infections, or new medications. Evaluation by her primary care physician during the time of the eruption included unremarkable antinuclear antibodies, thyroid stimulating hormone level, complete blood cell count, comprehensive metabolic panel, urinalysis, chest radiography, and lower-extremity Doppler ultrasonography.

Physical examination at the current presentation revealed numerous scattered, faint, erythematous, blanchable macules on the lower extremities along with

mild pitting edema (Figure 1). The patient’s current medications included cetirizine, which she had been taking for years, as well as an intrauterine device. A punch biopsy from the right lower leg revealed small, well-demarcated sarcoidal granulomatous inflammation surrounding vascular structures and skin appendages (Figure 2). No foreign bodies were observed with polarized light microscopy. Microscopic findings suggestive of an infection, including caseation necrosis and suppurative inflammation, also were absent. Angiotensin-converting



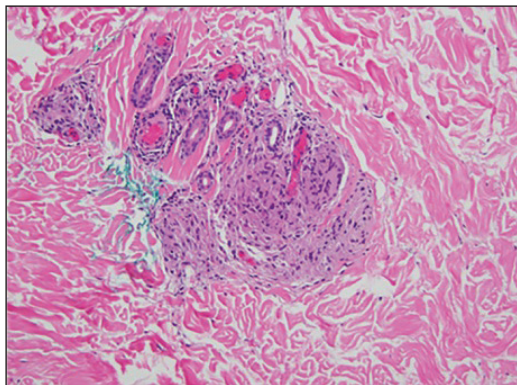
**FIGURE 1.** Numerous scattered, faint, erythematous, blanchable macules on the right foot.

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The authors report no conflict of interest.

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doi:10.12788/cutis.0460



**FIGURE 2.** A 4-mm punch biopsy from the right lateral distal pretibial region revealed small, well-demarcated sarcoidal granulomas within the reticular dermis surrounding vascular structures and skin appendages (H&E, original magnification  $\times 400$ ).

enzyme levels were normal. Myeloperoxidase and proteinase 3 IgG antibody levels were evaluated due to potential vascular involvement but were negative. An infectious cause of the sarcoidal granulomas was unlikely given histopathologic findings and negative tuberculosis skin testing, which the patient underwent annually for her job, so a tissue culture was not performed. The patient was prescribed triamcinolone acetonide cream 0.1% for the itching and burning at the initial visit and was continued on this treatment after the diagnosis of sarcoidosis was made. At 2-month follow-up, the patient's eruption had nearly resolved with topical therapy.

Cutaneous manifestation occurs in 20% to 35% of sarcoidosis cases and may develop in the presence or absence of systemic disease. Approximately 60% of individuals with cutaneous sarcoidosis are found to have systemic involvement; therefore, careful monitoring and

diagnostic workup are important in the management of these patients.<sup>2</sup> While most cases of cutaneous sarcoidosis are papular, it is important for clinicians to maintain a level of suspicion for sarcoidosis in any uncertain dermatologic presentation.<sup>1,2</sup> Evidence of telangiectasias has been shown in rarer forms of sarcoidosis (eg, angiulupoid), but the lesions usually are confined to the face, ears, or neck.<sup>3</sup> Granulomatous vasculitis has been reported in a small number of individuals with ulcerative sarcoidosis.<sup>4</sup> In our case, no ulcerations were present, possibly indicating an early lesion or an entirely novel process. Lastly, although reticular dermal granulomas are found in drug-induced interstitial granulomatous dermatitis, these lesions often are dispersed interstitially amongst collagen bundles and are associated with necrobiosis of collagen and eosinophilic/neutrophilic infiltrates.<sup>5</sup> The lack of these characteristic pathologic findings in our patient along with no known reported cases of cetirizine-induced granulomatous dermatitis led us to rule out reticular dermal granulomas as a diagnosis. We present our case as a reminder of the diversity of cutaneous sarcoidosis manifestations and the importance of early diagnosis of these lesions.

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