Clinical details supplied

- 51 year old female
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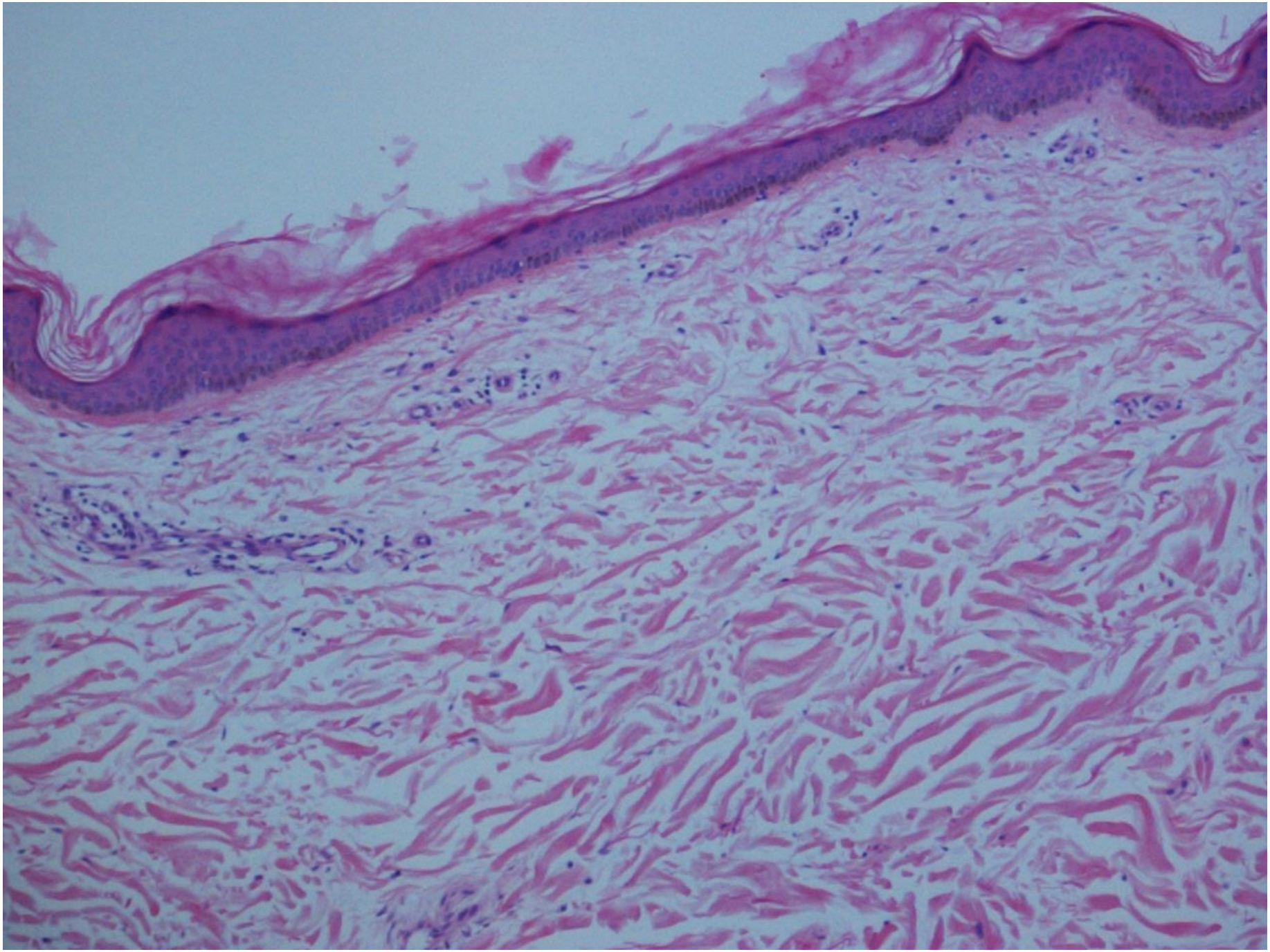
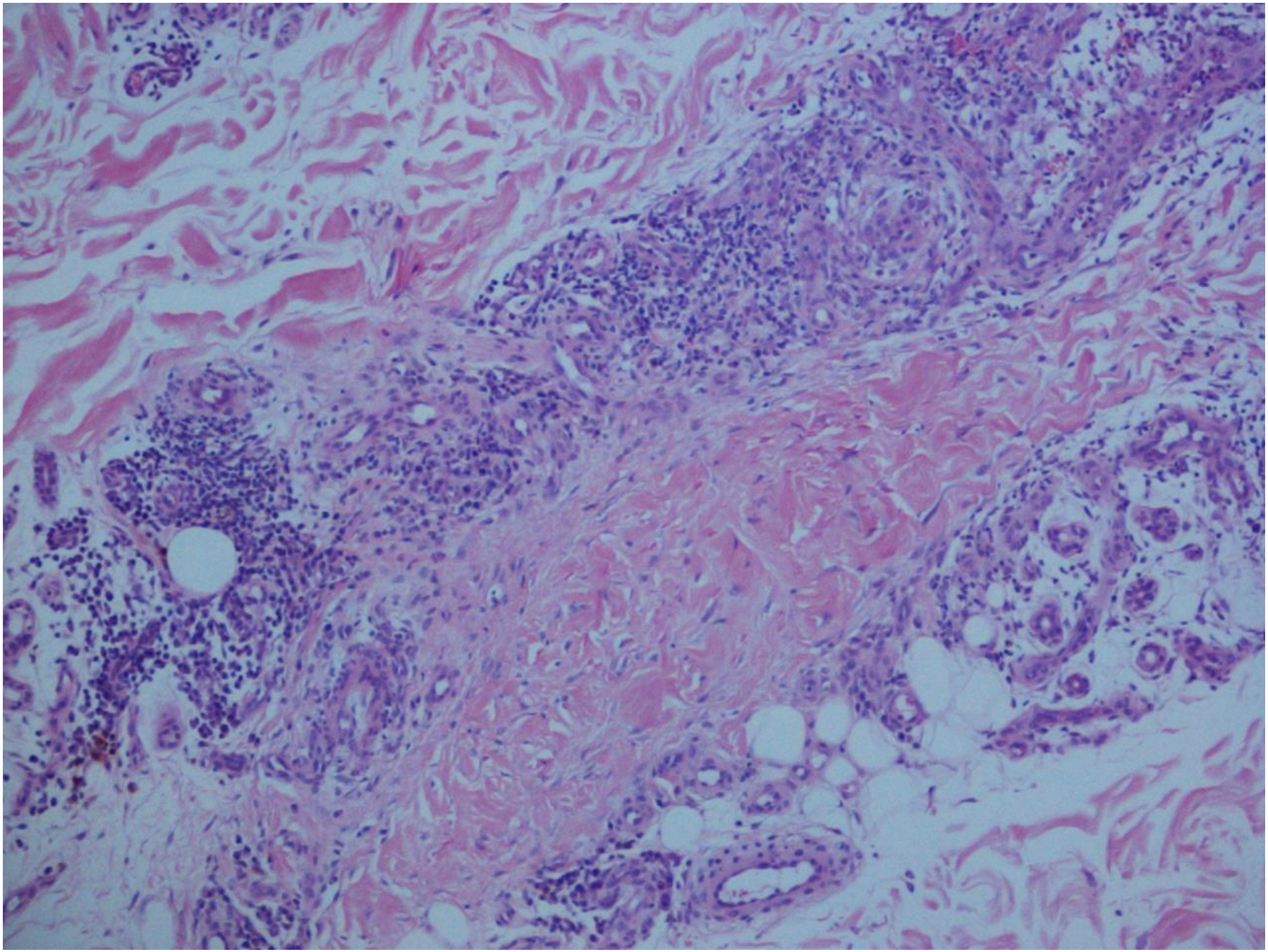
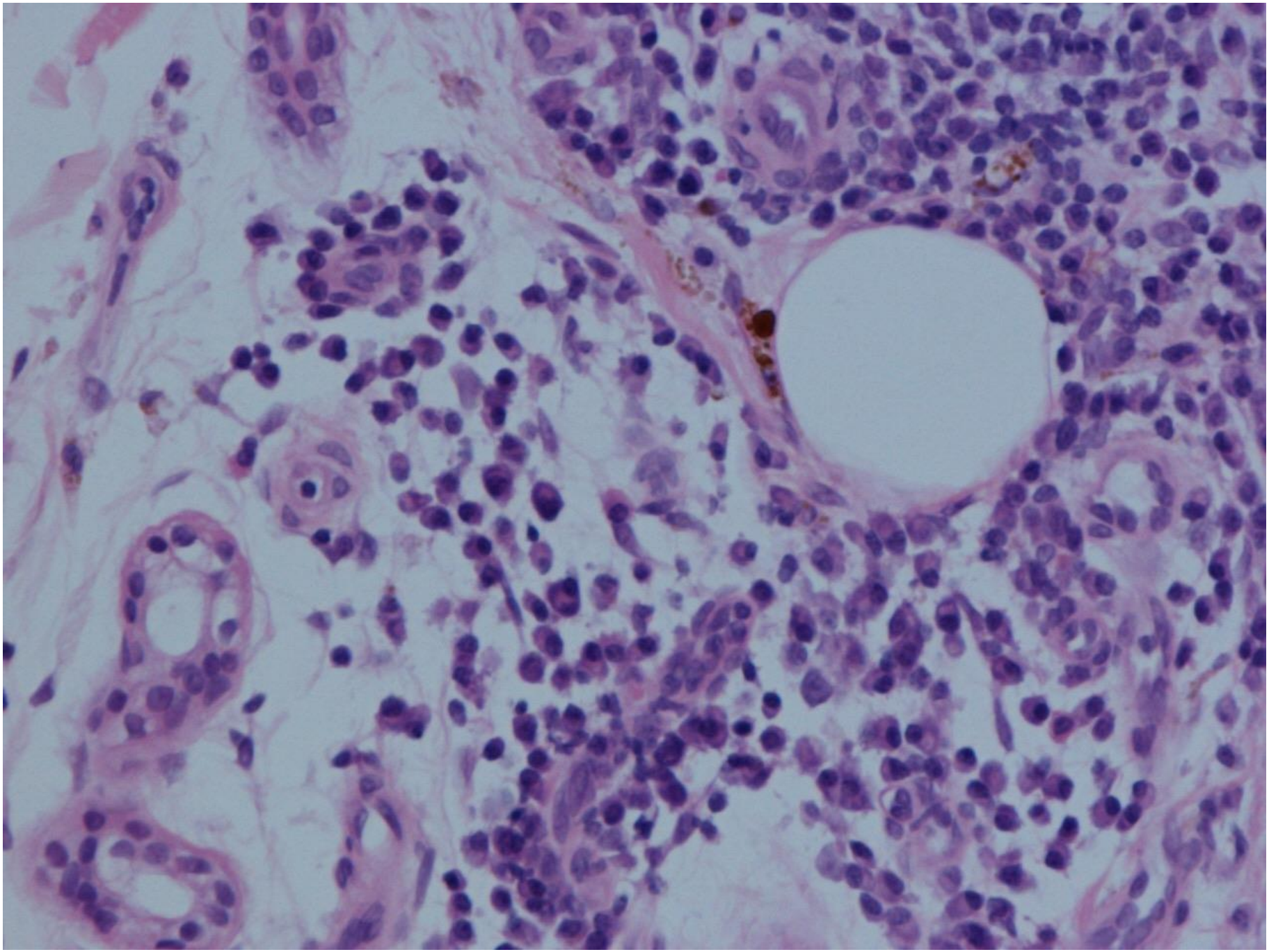
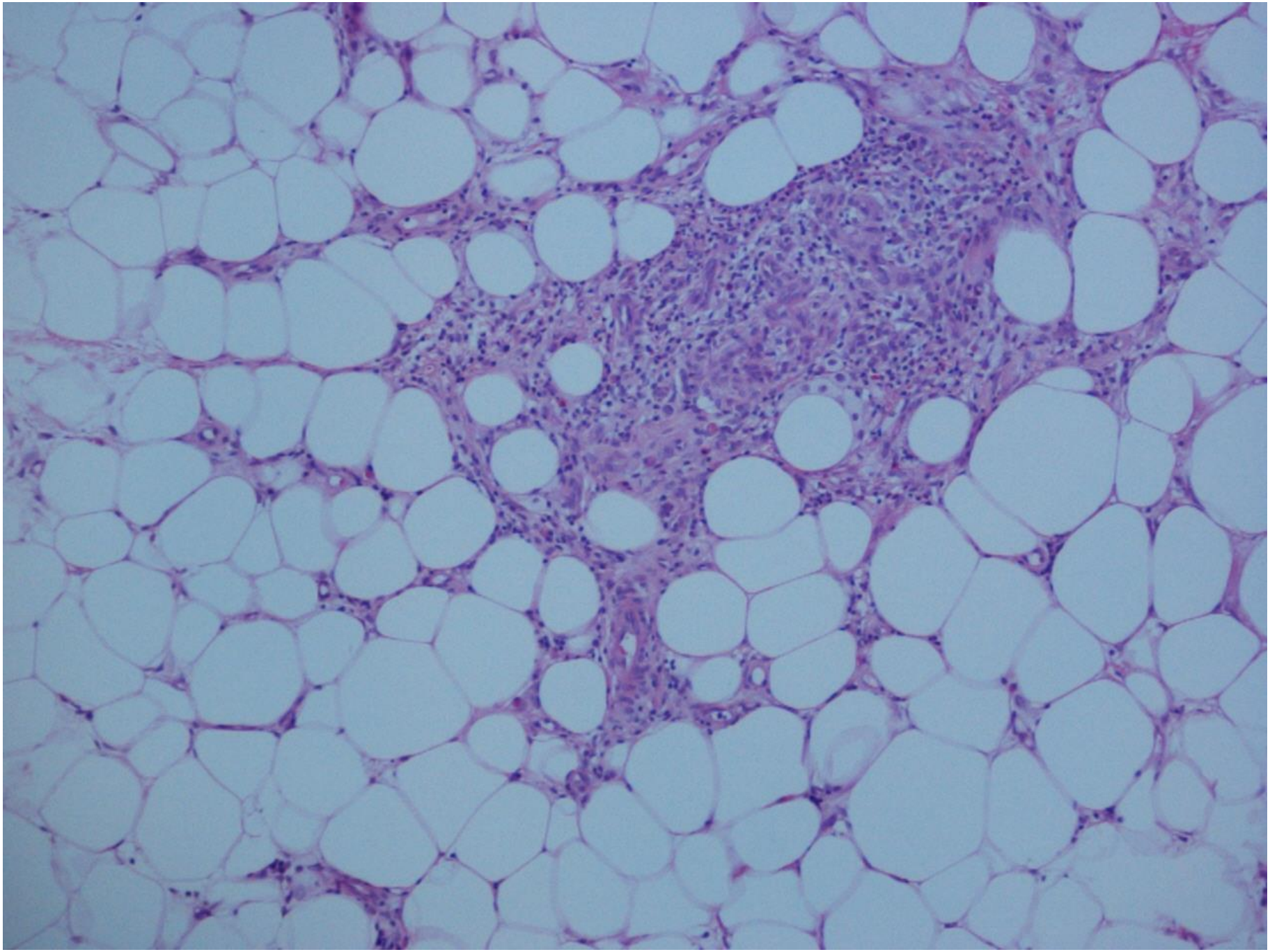
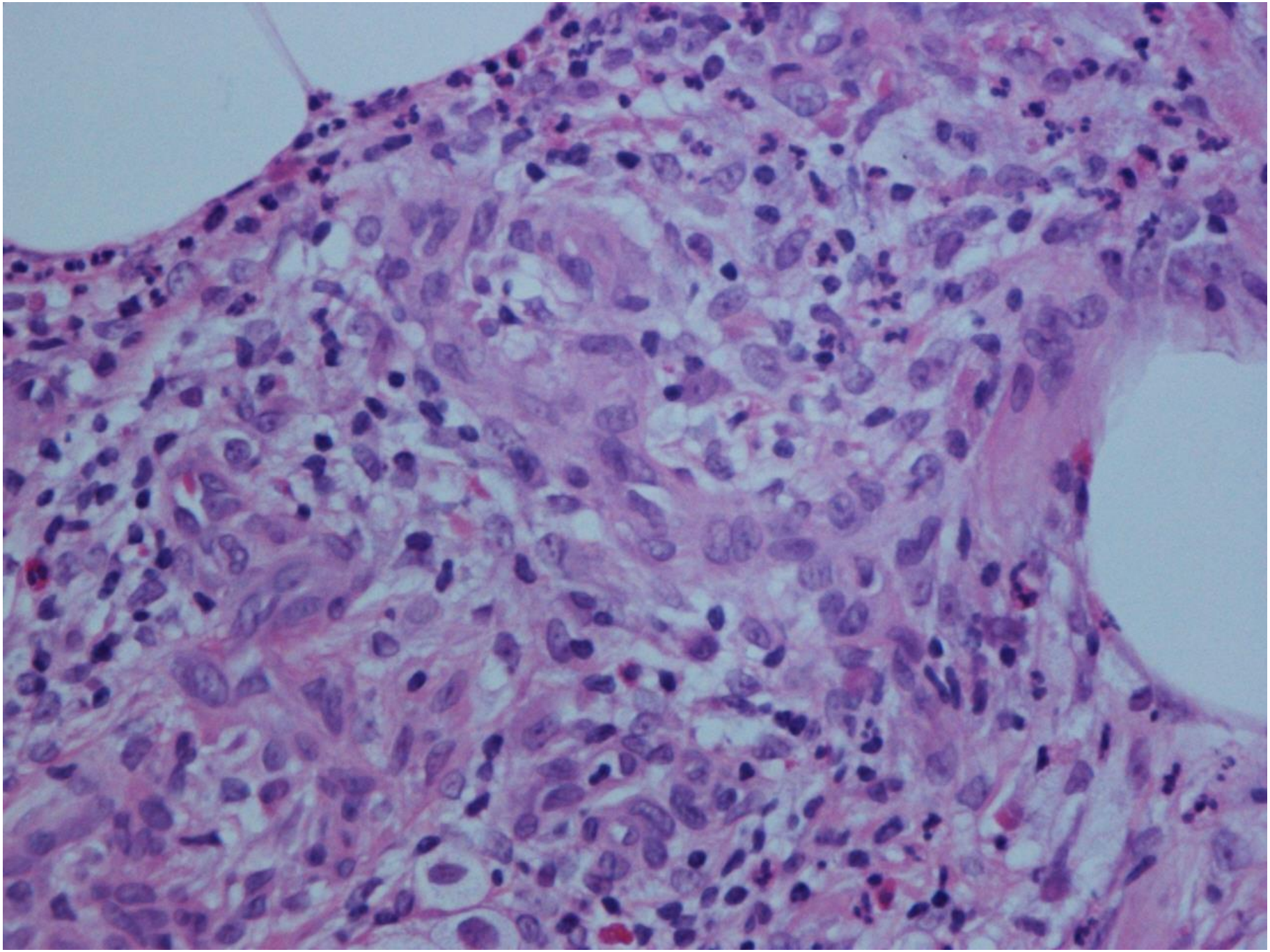
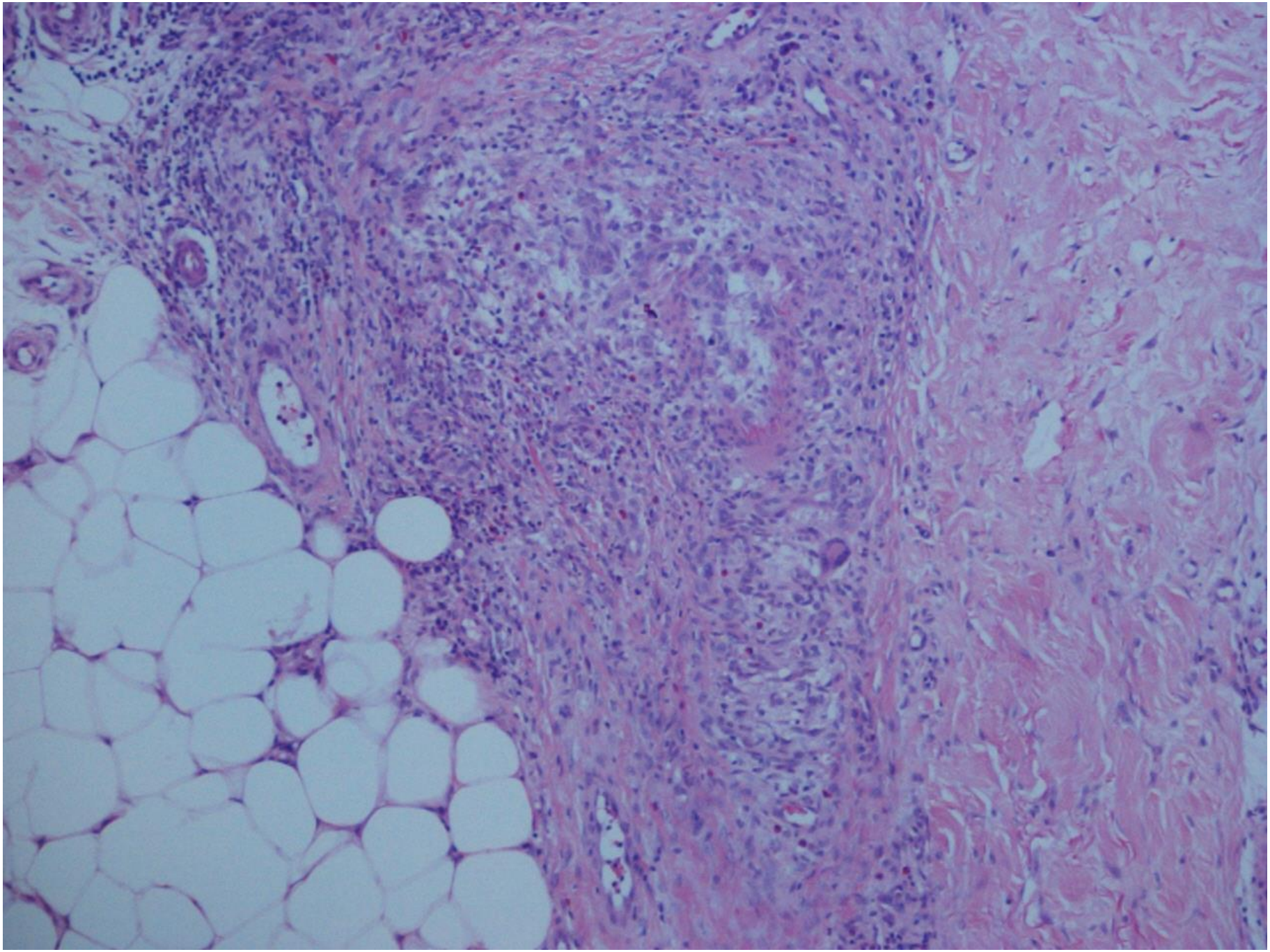












Granulomatous vasculitis with panniculitis

Differential diagnosis

1) Erythema nodosum
2) Erythema induratum
3) PAN
4) Granulomatous vasculitis
5) Sarcoidosis

The actual clinical history!

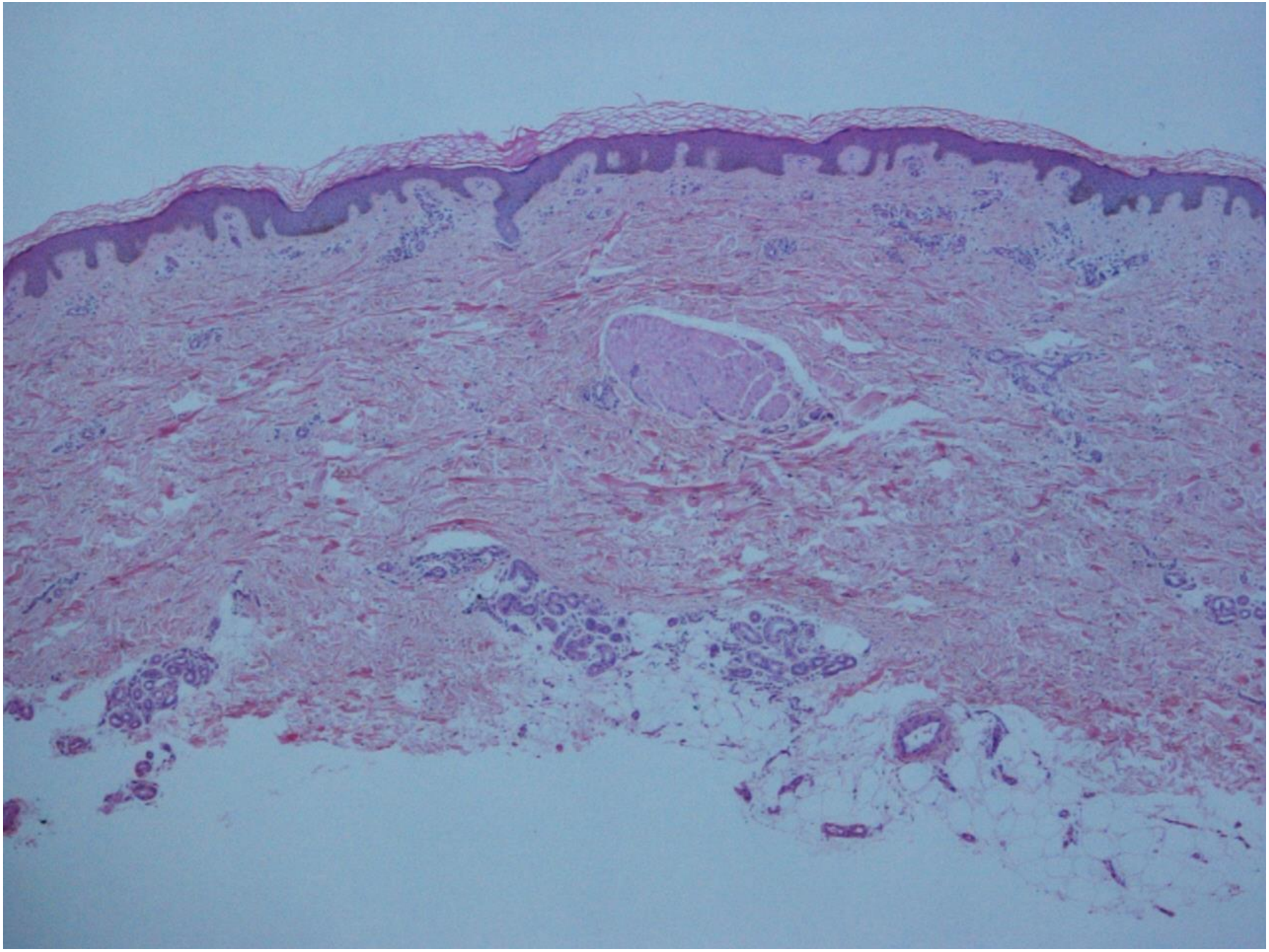
Rhematology July 2013

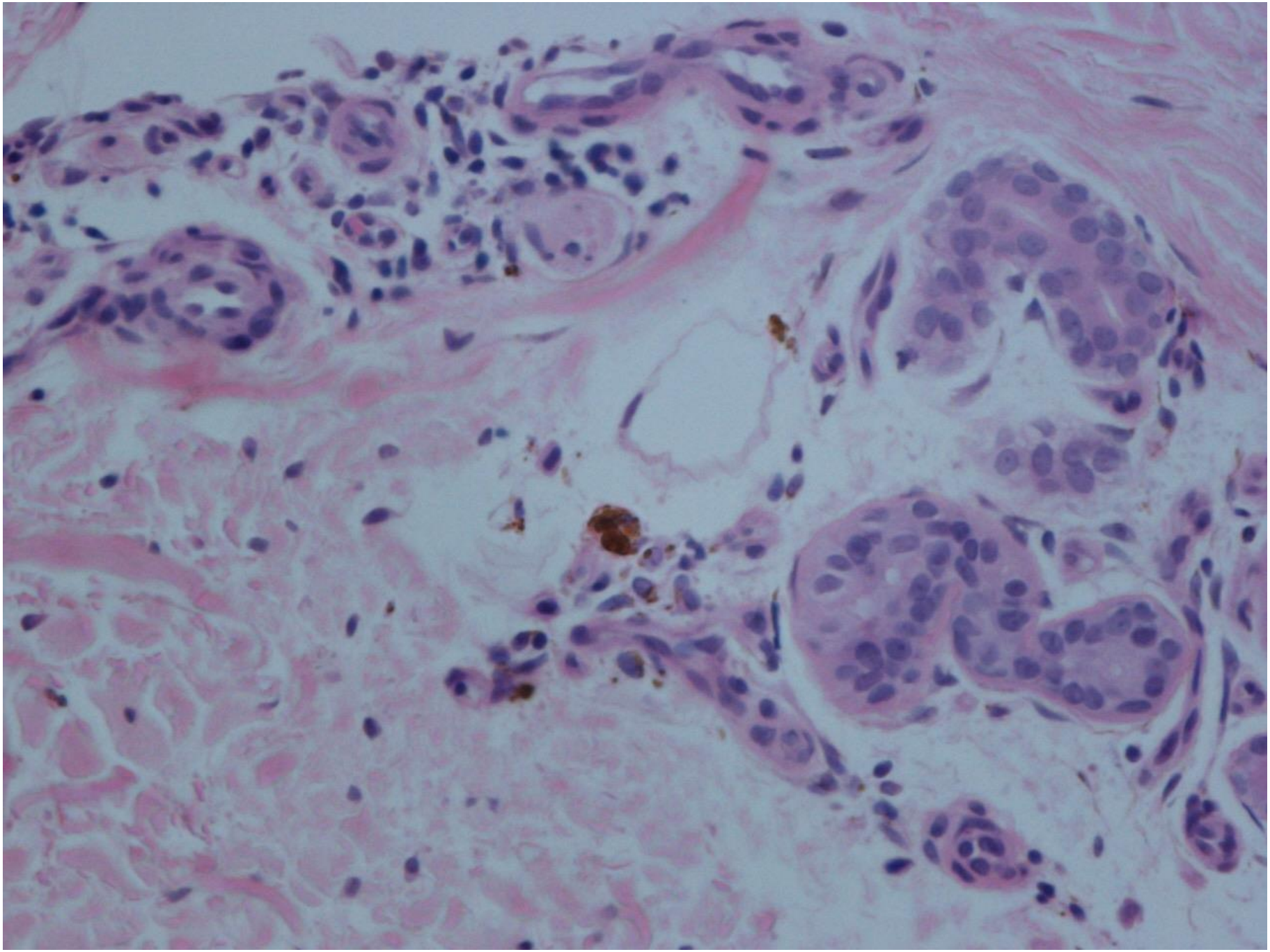
I would be grateful if you could see this 51 year old lady who has high grade ductal carcinoma in situ managed on tamoxifen. She describes a lesion over the right calf which first started following an insect bite and subsequently has increased in size over this time with various interventions including steroid creams not being effective for this. It continues to progress actively in terms of some erythema that would then form a desquamating brown lesion and gradually increase the margins of the lesion. Within the lesion itself there appears to be a central reticular-like pattern and a well-defined circular lesion that is brown superior to this. I am unsure of the significance of this and would be grateful for your opinion. Many thanks.

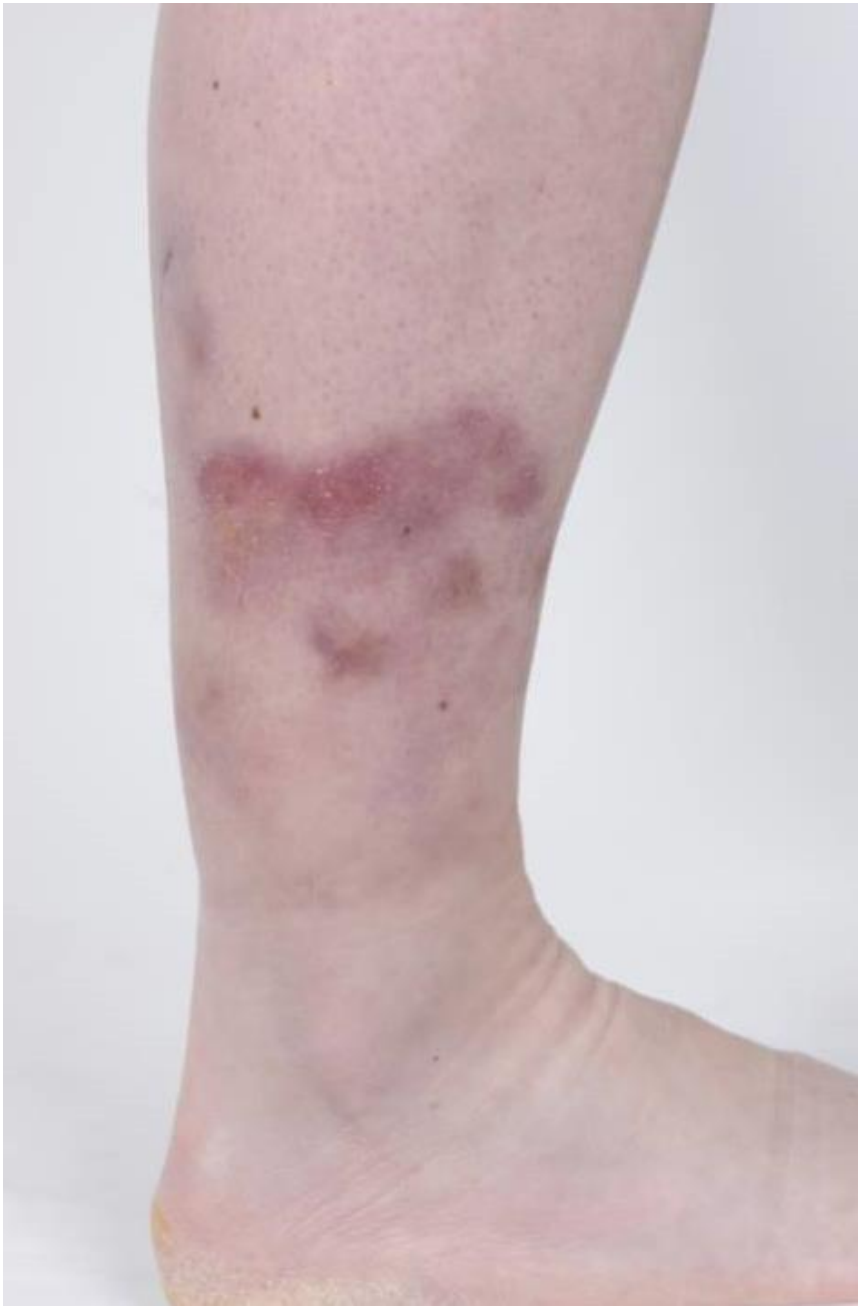
Derm Aug 2013

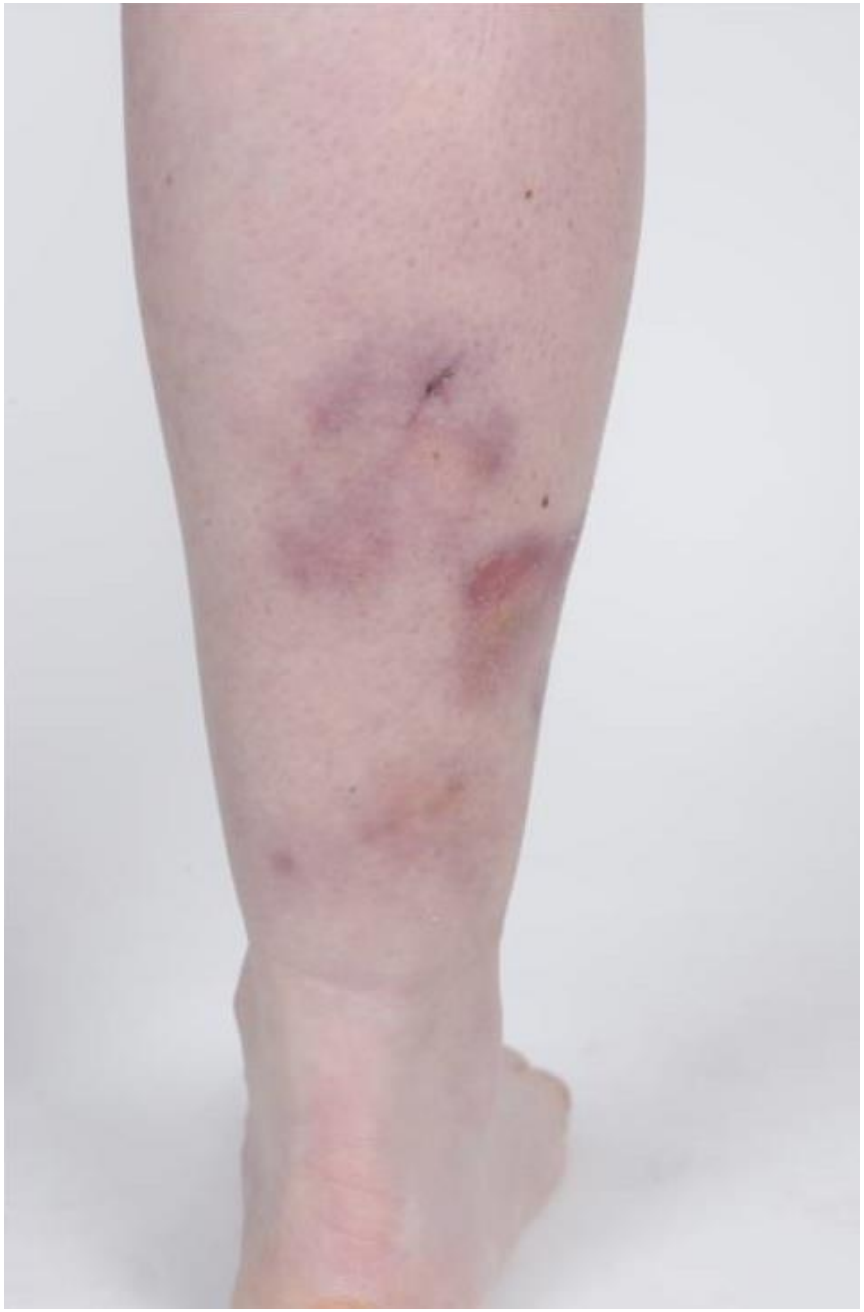
- On examination there is an area of livedo on her right calf with a scar about 3 cm diameter. There were lesser but definite areas of livedo on her buttock and right thigh as well. The rest of her skin is unremarkable.

- I think we do need to biopsy this but I wonder about something like a cutaneous PAN. I have checked her ANCA and various other bloods and have booked her in for an incisional biopsy as we need to include some fat.









Letter to GP 2017

DIAGNOSIS/PROBLEM: **Monoarthritis right knee – awaiting synovectomy**
Previous CA breast

CURRENT MEDICATION: **Methotrexate 25mg once weekly**

INVESTIGATIONS BOOKED: **CT – chest, abdomen & pelvis**

FOLLOW UP:

This lady has no symptoms in her other joints and she hasn't ever had any symptoms in her other joints. She is listed for right knee synovectomy and I would be grateful if samples could be sent for MCS and AFB when post-operatively.

The methotrexate has made no difference but she also has no side effects. She has skin lesions to both legs and now both hands. These are pigmented lesions but they are not itchy or painful. They don't strictly look like erythema nodosum but I am not sure what the cause is. She also has pitting oedema to both lower legs. I note that she has had a previous history of breast cancer. I will be referring to dermatology for an urgent opinion regarding the nature of her skin lesions. She obviously has synovitis to her right knee but none of her other joints are tender or swollen. Her chest is clinically clear.

I have arranged for a CT of her chest, abdomen and pelvis, quantiferon gold, ACE bone profile. We will await her synovectomy. She feels that the methotrexate has made no difference so she is quite keen to stop it so I have agreed that she can.

I will write to dermatology for an opinion regarding the skin lesions.

Letter to dermatology from rheumatology

I would be grateful if you could review this lady's skin lesions. She has had a previous history of breast cancer, has a monoarthritis and highly raised inflammatory markers and I am concerned about a possible disseminated malignancy. I would be grateful for your further advice and opinion.

Clinical details supplied

- 51 year old female
- Monoarthritis - Hx of breast Ca.
- Hyperpigmented mottled rash on lower legs. Lavido like changes - urticated rash.
- ?PAN, ?Urticaria vasculitis, ?Lupus panniculitis.

Positive Quantiferon

Letter from TB MDT meeting

As requested we discussed the above patient today in the TB MDT meeting.

Given [redacted]s positive Quantiferon test and other results to date, there does not appear to be any evidence of active TB disease, although please note the MDT does not consist of a radiologist to review the imaging.

The recommendation from the TB MDT today is that this patient should be offered treatment for possible latent TB with 3 months of Rifampicin and and Isoniazid. If the patient is very reluctant for this then it should be noted that the likelihood of reactivation of TB is likely to be around 1% per year and we would only very strongly recommend latent TB treatment if the patient was being considered for biologic therapy in the future.

We do not plan to discuss [redacted]s case further however please feel free to contact us

Erythema induratum of Bazin

- Tuberculin hypersensitivity
- Indolent, mildly tender, dull red nodules ranging in size from 5 to 7.5 cm
- Usually develop on calves
- Four times more common in women
- Granulomatous vasculitis affecting subcutaneous large vessels associated with septolobular panniculitis
- Mycobacterial DNA can be found in up to 77% of skin biopsy specimens
- Lesions may ulcerate
- Ragged, irregular and shallow ulcers with bluish edge
- Commonest form of cutaneous tuberculosis found in Hong Kong

Application of the QuantiFERON®-TB Gold test in Erythema Induratum

Ji Hoon Sim Department of Dermatology, College of Medicine, Soonchunhyang University, Seoul, South Korea & Kyu Uang Whang Department of Dermatology, College of Medicine, Soonchunhyang University, Seoul, South KoreaCorrespondencesnolomas@schmc.ac.kr

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Abstract

Erythema induratum (EI) was originally described by Ernest Bazin in 1861 as nodular lesions on the legs in association with tuberculosis (TB). A 33-year-old woman was referred to our hospital with tender ulcerative nodules on her legs. Skin biopsies revealed lobular inflammation of the subcutaneous fat with vasculitis. Although conservative treatment was given, the lesions did not improve. Several months later as the lesions persisted, we suspected a TB infection and additional tests were performed. The chest roentgenogram results were normal. The skin biopsies were negative for acid-fast bacilli (AFB). Mycobacterial cultures of the blood and skin were negative. However, the QuantiFERON®-TB Gold test was positive, which led to a diagnosis of latent TB infection being made. The patient was treated with multidrug antituberculosis therapy, which successfully resolved her skin lesions. Therefore, reported herein is the application of the QuantiFERON®-TB Gold test for the confirmation of latent TB infection in EI patients.