Case report

Lupus vulgaris in an immunocompromised patient

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Interest in tuberculosis (TB) has recently increased, particularly in developing countries, in response to a resurgence in human immunodeficiency virus (HIV) infection¹,² and multidrug-resistant pulmonary TB. Cutaneous TB is relatively rare in the Western world. However, it accounts for 0.4% of patients with skin diseases in the Far East³ and its incidence has fallen from 2.0% to 0.15% in India.⁴

Among a large variety of cutaneous TBs, lupus vulgaris is the most common morphological variant, accounting for approximately 59% of cases of cutaneous TB.⁵ Lupus vulgaris is typically a chronic and progressive form of cutaneous TB acquired via endogenous spread or direct exogenous inoculation. Typical sites of lupus vulgaris lesions vary from country to country. The most common sites of lupus lesions in patients in European countries are on the head and neck, whereas sites of predilection in patients in India are the buttocks and trunk.⁶⁻⁸ These variations are likely to reflect differences in the underlying socioeconomic status of patients and environmental factors.

Lupus vulgaris is diagnosed based on a combination of clinical presentation, histopathological examination, and culture results. A majority of cases of lupus vulgaris, both confirmed and presumptive, have been treated with anti-TB drugs with good response.⁹⁻¹⁰ Treatment duration varies from six months to one year.

We report a case of lupus vulgaris in an immunocompromised woman in Malaysia, who was successfully treated with antituberculous therapy.

The patient was a 39-year-old Chinese woman with a medical history of hypertension. She had received a renal transplant from a living related donor in 2000. Post-transplant, the patient had been well until the middle of 2010, when she presented to the dermatology clinic with a 2-month history of multiple ulcers over both upper arms. The condition had initially manifested on the right arm as a nodule that ulcerated spontaneously and was followed by two further nodules on the right elbow and left arm. The nodules were of varying size and had well-defined margins. They were painless and ulcerated spontaneously, discharging pus, which became dry and crusted. They became progressively enlarged over a 2-month period. The patient had lost weight amounting to about 3 kg over the two months. However, she reported no fever, night sweats, cough, or other symptoms of respiratory tract infection. She denied any history of TB or contact with TB patients.

The patient’s renal transplant had been performed in July 2000. The cause of kidney failure was uncertain because no renal biopsy was carried out at the time. Post-transplant, the patient suffered acute, followed by chronic, graft rejection. Throughout her illness, her baseline creatinine remained stable at 170–190 µmol/L. She has since remained on immunosuppressants which consist of oral prednisolone, mycophenolate mofetil and tacrolimus.