CO-EXISTENCE OF TUBERCULOSIS AND DISCOID LUPUS ERYTHEMATOSUS

A case report

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INTRODUCTION

Tuberculosis (TB) is a global health concern and Africa scores the majority of cases. Cutaneous TB is uncommon, comprising 1-1.5% of all extrapulmonary tuberculosis manifestations. Its diagnosis is challenging and relies mainly on histopathology, culture and DNA amplification methods. Sometimes it is only clear after a therapeutic trial with anti-tuberculosis drugs. However, even in the setting of a non-cutaneous tuberculosis infection, the unapparent cutaneous response to treatment poses other differential diagnosis.

CASE REPORT

14-year-old girl, from Guinea-Bissau

6-month: Recurrent low-grade fever, cervical tumefaction
Poor appetite, Weight loss (11%)
Erythematous papular scaly skin lesions (face, ears, arms)
Cervical + Supraclavicular lymphadenopathies

Laboratory findings:
- Tuberculin skin test - POSITIVE
- IGRA test - POSITIVE
- ADA: 41.9 U/L
- HIV 1+2 antibodies: negative
- Gastric aspirate + lymph node culture – POSITIVE

Ganglionar Biopsy:
Granulomatous lymphadenitis + areas of central caseous necrosis

1st skin biopsy — Lichenoid dermatitis
BK Culture + PCR negative

No cutaneous improvement with Anti-TB drugs!
- Atrophic hyperpigmented plaques (face, ears)
- Erythematous nodular lesions (fingers)
- Onychodystrophy + acral scaly lesions

2nd skin biopsy — Discoid Lupus Erythematosus

No evidence of multi-systemic involvement
Renal... Neurological... Articular... Mucosal...

ANAs: Positive (1/160)
Anti-dsDNA: Normal
Anti-SSA (Ro), SSB (La), RNP, Sm, Jo1, Sc1-70: Negative
ANCAc, ANCAPc: Normal
Anti-J2GP1, Anti-cardiolipin: Negative
Complement C3, C4, CH100: Normal
Lupus anticoagulant (PTT, DRVVT): Negative

Leukopenia < 4000/µL
No hemolytic anemia
Normal platelets
Coombs test negative
ACE: Normal
Ca2+/Cr ratio: Normal
Urea, Creatinine: Normal

DISCUSSION

Both pulmonary and extra-pulmonary forms of TB have a good outcome when treatment is strictly followed. However, in the absence of cutaneous improvement, after exclusion of TB drug resistance, it was imperative to think of other causes. Given the result of the second skin biopsy, a Lupus-like syndrome had to be considered. Isoniazid is the most likely implicated drug, but lesions were present before treatment and no reversibility occurred after drug suspension. In cutaneous lupus erythematosus presentation, there is a 25% rate of progression to systemic disease. In our patient, there was no systemic involvement besides positive ANAs 1/160 and mild leucopenia. To the best of our knowledge, there is no evidence of association between TB and discoid lupus erythematosus (DLE). Since DLE might be associated with systemic lupus erythematosus, these children require regular monitoring for systemic disease.