QUIZ SECTION

Three Cephalic Plaques: A Quiz

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A 74-year-old male presented with 3 infiltrated angiomatous plaques on his vertex and forehead for 6 months (Fig. 1), which were asymptomatic. He had a medical history of prostate cancer in 2016. He had controlled plaque psoriasis and gout, a drug rash following allopurinol introduction, but no other notable history. Clinically, the patient had neither other similar plaques nor adenopathy. Biopsy showed a neutrophilic and eosinophilic infiltration in the superficial and mid-dermis, a Grenz zone, rich vascularization and multiple capillaries, a minimal perivascular fibrosis and an intact epidermis (Fig. 2). Laboratory tests revealed no eosinophilia or any other anomalies.

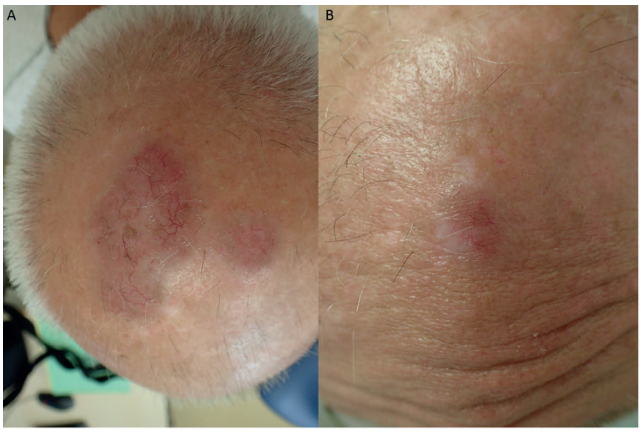

Fig. 1. (A) Two angiomatous plaques of the vertex. (B) Lesion of the forehead.

What is your diagnosis? See next page for answer.

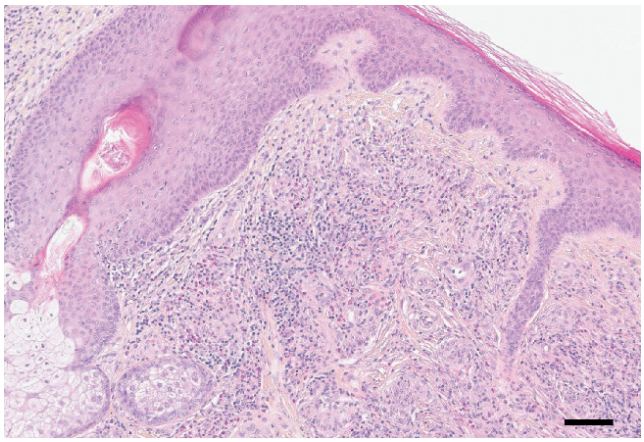

Fig. 2. Mixed dermal infiltrate formed by lymphocytes, histiocytes, plasma cells and neutrophils and a grenz zone (haematoxylin and eosin, original magnification ×400). Black bar; 100 µm.

ANSWERS TO QUIZ

Three Cephalic Plaques: A Commentary

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Diagnosis: **Extrafacial granuloma faciale**

Extrafacial granuloma faciale (GF) is a limited cutaneous disease of unknown aetiology (1). Middle-aged light-skinned men are commonly affected. GF is expressed by the presence of 1 or multiple plaque/nodule lesions of red-brown to violaceous colour with follicular accentuation and telangiectasia. Isolated facial presentation is commonly reported in the literature, but some patients also have associated extrafacial lesions. Approximately one-third of patients (31%) had isolated extrafacial lesions in a reported series of 32 patients (2). The trunk is usually the most frequently affected zone, followed by the upper extremities and the scalp (2). The pathophysiology of GF remains unknown, but it is probably related to sun exposure, as the lesions are generally found in photo-exposed areas. As diagnosis is based on histopathology, any well-demarcated infiltrated plaque should be biopsied (3). GF is frequently resistant to conventional therapy. Topical and injectable corticosteroids or tacrolimus and dapsone have been proposed, and combination with cryotherapy can also be used to obtain a better sustainable therapeutic response (2–4).

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