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Histioid Leprosy a Rare Variant: First Report in Ecuador [[es]]Lepra histioide, una variante rara: primer reporte en Ecuador[☆]



To the Editor:

Histioid leprosy (HL) is a rare variant of lepromatous leprosy with characteristic clinical, histopathological, bacteriological and immunological findings.¹ We report the first documented cases of HL in Ecuador.

A 44 years-old male with a history of lepromatous leprosy successfully treated 2 years ago with complete WHO multidrug therapy (MDT) scheme, with improvement in clinical features and negative bacilloscopy. However, during the treatment and subsequent medical follow-up the patient presented erythema nodosum leprosum that was treated successfully with thalidomide in another hospital. In the last 6 months the patient presented generalized erythematous-violaceous nodules, hiperpigmented macules and patches on the face, trunk and limbs that respect palms, soles and mucosa, with malaise, paresthesias in upper limbs and thickening of ulnar nerves (Fig. 1A, B). Bacilloscopy was positive in the ear ++, elbow + and knee +. The

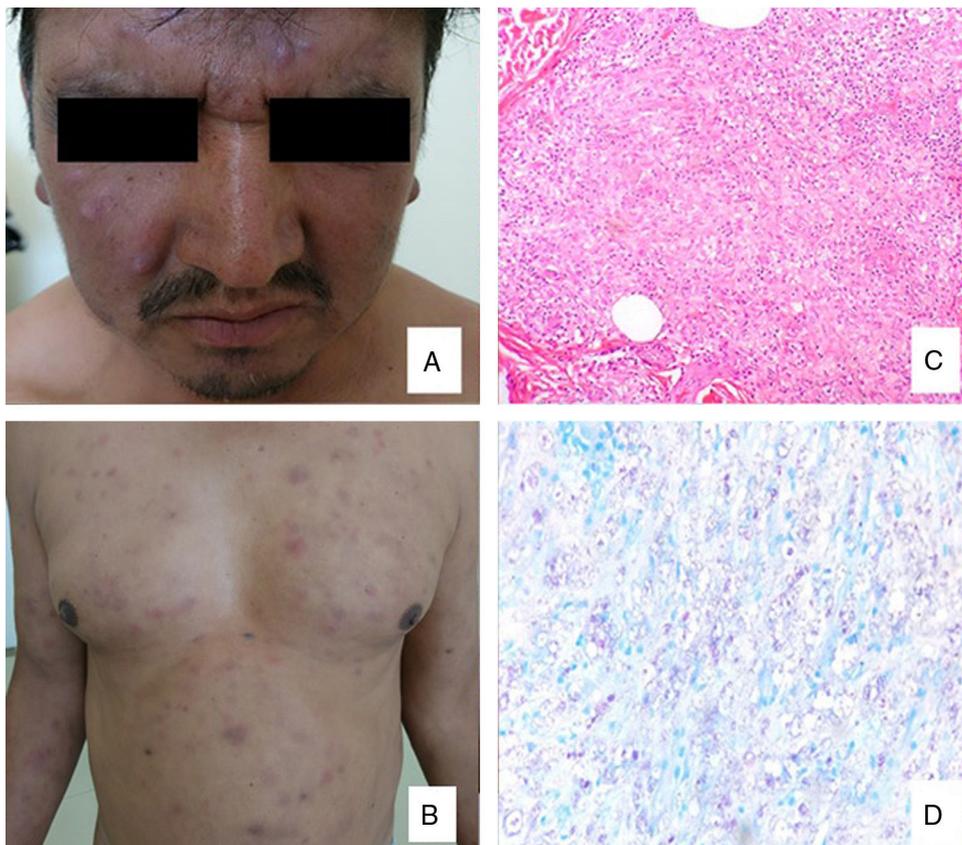


Fig. 1 A. Nódulos eritematovioláceos con distribución centroracial sobre la frente y las mejillas. B. Varios nódulos en forma de cúpula de consistencia firme y parches en el tronco. C. Histiocitos fusiformes con tendencia a la nodularidad (H-E x40). D. Bacilos ácido-alcohol resistentes intracitoplasmáticos en macrófagos (Ziehl-Neelsen X100).

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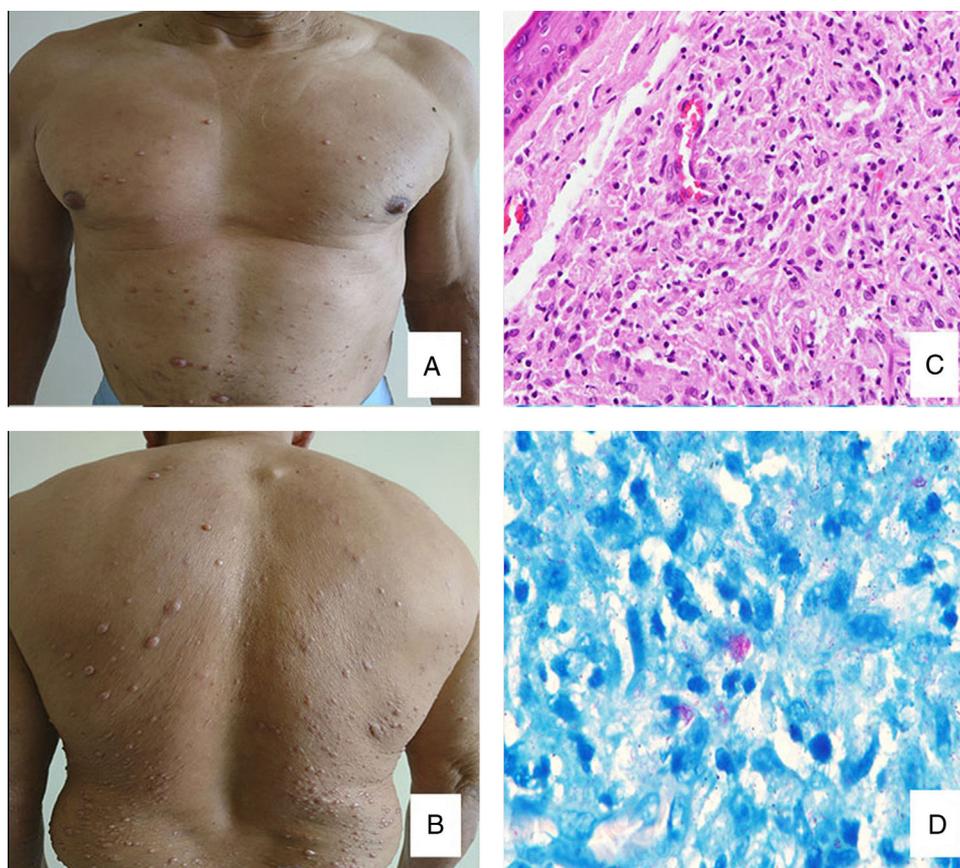


Fig. 2 A y B. Nódulos color piel en el tronco y antebrazos. C. Atrofia epidérmica, zona de Grenz, y acúmulo circunscrito de histiocitos fusiformes en la dermis (H-E x40). D. Globus y bacilos ácido resistentes aislados (Wade-Fite stain x100).

histopathological study shows fusiform histiocytes with a tendency to nodularity and identifies acid-alcohol resistant bacilli intracytoplasmic in macrophages, compatible with histioid leprosy (Fig. 1C, D). The patient is being treated with MDT and we added minocycline 100 mg with good clinical response by decreased size and disappearance of some nodules at the third month.

The second case is a 52 years-old male with no relevant personal history who presents asymptomatic generalized skin color nodules, mainly localized in trunk and proximal limbs (Fig. 2A, B). The bacilloscopy was positive in the ear ++, elbow ++ and knee +. The biopsy shows a thinned epidermis with a Grenz zone and diffuse dermal proliferation of epithelioid-vacuolated histiocytes with fusiform cells and moderate lymphocytic infiltrate. Virchow histiocytes are also around the nerves (Fig. 2C). Wade-Fite stain shows globus and isolated acid resistant bacilli, which confirms the diagnosis of histioid leprosy (Fig. 2D). The patient is being treated with WHO MDT.

By 2003 leprosy had been eliminated from 117 countries, but the disease continues to present a public health problem in 17 countries.² It remains an enigmatic form of leprosy mostly reported from India, Brasil, Birmania and constitutes 1,2-3,5% of all leprosy cases, with male predominance in age range of 20-50 years; however, studies regarding this form of disease are very rare.¹⁻⁴ HL has been reported generally to manifest in patients after long-term dapsone monotherapy, irregular or inadequate therapy, there are also reports of

disease developing as relapse after successful treatment.¹ However, de-novo cases of HL have also been encountered, as our second case.

The etiopathogenesis of this entity is not clear, but has been suggested to represent a hyperactive expression of multibacillary leprosy in an effort to restrict or focalize the disease.⁵ The interplay of genetic factors, immune response and treatment received in a given patient seems to influence the manifestations of HL.² According to Sehgal et al. probably some groups of histiocytes work different from others, this would explain why a combination of ordinary lepromas and histioid nodules can be found in the same patients.³ The most accepted theory is that proposed by Civatte, who pointed out that the histiocyte grows slowly and begins to produce large amounts of collagen under an unknown stimulus. This hyperplasia produces an inflammatory process that subsequently results in the formation of a nodule.⁶

Clinically the histioid lesions appear as smooth, shiny, erythematous or coppery color, dome-shaped, nontender soft to firm nodules which may be superficial or subcutaneous and plaques appearing on otherwise normal looking skin.⁷ The localization is usually on the posterior and lateral aspects of the arms, buttocks, thighs, dorsum of the hands, lower part of the back, and over the bony prominences, especially over the elbows and knees. Lesions vary in size and consistency, usually of 1.5-3 cm.⁸ Mendiratta et al. and Nair and Nanda Kumar have reported frequencies of erythema nodosum leprosum (ENL) among HL cases of 40%, 27% and

24% respectively.^{1,9} It has been proposed that ENL probably occurs in patients during the transition to manifest HL,¹ as our first case.

The instant confirmation of histoid leproma is made with smears test, which has a specificity of 100% and a sensitivity of 50%, and can be obtained from nasal mucosa, an ear lobe or skin lesions.²

Histopathological findings are unique, epidermis may be normal or atrophic with a Grenz zone. The leproma consists of fusiform histiocytes arranged in a whorled, criss-cross, or storiform pattern.⁵ Within the histiocytes, plenty of acid fast bacilli can be found. They are longer than the normal bacilli, are uniform in length and are arranged in parallel bundles along the long axis of the spindle histiocytes with or without globus formation.³ In addition the factor XIIIa positive is characteristic and the loss of S100 expression.¹⁰

It has been treated on the lines of multibacillary leprosy with the recommended WHO MDT.³ Researchers have also managed initially by giving the range of motion therapy, with rifampicin 600 mg, ofloxacin 400 mg, and minocycline 200 mg, which is followed by MDT.⁸

To conclude, it is important to recognize atypical leprosy presentations to continue the surveillance for new cases, since early diagnosis and complete treatment are important to achieve our goal of eliminating leprosy. Furthermore, continuous medical follow-up must be done after a multidrug therapy in order to detect these rare variants.

References

- Nair S, Nanda Kumar G. A clinical and histopathological study of histoid leprosy. *Int J Dermatol.* 2013;52:580–6.
- Eichelmann K, González S, Salas J, Leprosy Ocampo J. An update: Definition, pathogenesis, classification, diagnosis, and treatment. *Actas Dermosifiliogr.* 2013;104:554–63.
- Sehgal V, Srivastava G, Singh N, Prasad P. Histoid leprosy: the impact of the entity on the postglobal leprosy elimination era. *Int J Dermatol.* 2009;48(6):603–10.
- Moreno T, Mancía S, Di Martino B, Rodríguez M, Knopfmacher O, et al. Hansen lepromatoso histioide. Características clínicas y epidemiológicas en pacientes de la cátedra de dermatología del hospital de clínicas. Facultad de ciencias médicas de la Universidad Nacional. Asunción. Paraguay. *Fontilles Rev Leprol.* 2013;29:109–11.
- Gupta SK. Histoid leprosy: review of the literature. *Int J Dermatol.* 2015;54:1283–8.
- Albrecht A, Leban V, Guardati M, Iribas J. Lepra histioide o de Wade. Presentación de un caso clínico. *Rev Argent Dermatol.* 2018;99:1–10.
- Kantaria S. De novo histoid leprosy. *Indian Dermatol Online J.* 2014;5(4):556–8.
- Annigeri S, Metgud S, Patil J. Lepromatous leprosy of histoid type. *Indian J Med Microbiol.* 2007;25:70–1.
- Mendiratta V, Jain A, Chander R. A nine-year clinicoepidemiological study of histoid Hansen in India. *J Infect Dev Ctries.* 2011;5:128–31.
- Sánchez A, Albízuri M, González T, Sendagorta E. Pruritic lesions during pregnancy: an unusual presentation of a rare variant of multibacillary leprosy. *Actas Dermosifiliogr.* 2016;107:352–4.

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Heparin-Induced Skin Necrosis Occurring at a Distance From Injection Sites[☆]



Necrosis cutánea por heparina con afectación a distancia del punto de administración

To the Editor:

A 67-year-old man who had been diagnosed 1 year earlier with inoperable glioblastoma multiforme that was refractory to multiple treatments was treated with low-molecular-weight heparin (LMWH) after an episode of pulmonary thromboembolism and deep venous thrombo-

sis. Disseminated asymptomatic skin lesions appeared 5 days after beginning LMWH therapy. Despite the spectacular appearance of the skin lesions the patient's general condition was excellent. Fever and other clinical signs of infection were absent. Physical examination revealed large, noninfiltrated ecchymotic plaques located mainly on the abdomen without underlying fluid collection (Fig. 1A), necrotic lesions on the right thigh (Fig. 1B), and tense blisters with hemorrhagic content in the distal area of the right leg (Fig. 1C).

Based on the patient's clinical picture a suspected diagnosis of heparin-induced skin necrosis was established. Laboratory tests, including a complete blood count and coagulation parameters, revealed no findings of interest, apart from thrombocytopenia (107 000 platelets/mL). Tests for anti-platelet factor 4 antibodies were negative. Heparin treatment was immediately discontinued and oral anticoagulation treatment with warfarin was initiated. Fifteen days after heparin discontinuation a clear improvement in the patient's lesions was observed (Fig. 2) and the platelet count returned to 130 000 platelets/mL. Skin necrosis in response to anticoagulant treatment is a rare adverse

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