Scrofuloderma with psoriasis - A case report

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ABSTRACT
Scrofuloderma is caused by tuberculous involvement of the skin by direct extension, usually from underlying tuberculous lymphadenitis, which is rarely seen in psoriatic patients. We report a case of psoriasis with scrofuloderma, where, the patient presented with bilateral groin swellings for last two months which ruptured few days back along with purulent discharge. Smear was made from this purulent discharge and acid fast bacilli were demonstrated in it. There were erythematous scaly lesions all over the body with silvery white scales, pain and deformity in small joints of hands.

Key words: tuberculous, psoriasis, scrofuloderma, acid fast bacilli

INTRODUCTION
Psoriasis is a chronic, relapsing and remitting inflammatory skin and joint disease that has prevalence of 2-3% of world population.1 Men and women are equally affected and exhibit a bimodal distribution with a peak between 15-30 years of age and another between 50-60 years of age.1 It results from the interaction between genetic and environmental factors and can cause significant impairment of physical, emotional and psycho-social well being of patients.2 3

Now-a-days many biological agents such as tumor necrosis factor-Alpha (TNF-α) inhibitors are used for psoriasis treatment along with the traditional therapies.4 5 All the TNF-α inhibitors are associated with an increased risk of developing active disease in patients with latent tuberculosis infection. Psoriasis per se could represent an independent risk factor for tuberculosis since, interestingly, an unexpected high prevalence was found in patients affected by latent mycobacterium tuberculosis infection (LTBI=18%).6 There are only scattered reports of pulmonary TB in psoriatic patients, but none of scrofuloderma.7 This prompted us to report this interesting case.

CASE REPORT
58 years old man, married and shopkeeper by occupation came to the outpatient department with complains of bilateral groin swellings, ulcers, skin lesions and painful small joints of hands. Two months back, he had bilateral groin swellings, 2-3 inches in size initially, which gradually increased in size and ruptured. Now he was having bilateral inguinal ulcers with undermined edges and purulent discharge. He gave history of erythematous plaque with silvery white scales over the limbs for last 20-25 years. He had been treated by general practitioners with pain killers, steroids and a variety of topical agents. The disease started from extensor aspect of the extremities and was progressive in nature involving whole of upper and lower limbs and few lesions on the back and chest. History of seasonal variation with winter exacerbation was also observed. In the beginning there were periods of remission, later on the disease progressed and involved the small joint of both hands without remission. He consulted a dermatologist and got skin biopsy done and was diagnosed as a case of psoriasis. He was treated with pain killers, cetirizine, methotrexate, cyclosporine and topical steroids. He got some relief but not complete cure. He kept on changing doctors. Patient was non alcoholic and non smoker, with no family history of such disease.

On clinical examination he was afebrile with normal pulse, BP and respiration. Local examination revealed erythematous scaly lesions scattered all over the body. On scratching the lesions scales became prominent and on further scratching there was pinpoint bleeding. Hands showed flexion
deformities at interphalangial joints bilaterally. In
the groins, there were firm lymphadenopathy and
ulcers of 2.0X3.0 inches in size with undermined
edges. These ulcers were covered with necrotic
slough and purulent discharge. On removal of
slough, unhealthy granulation tissue was seen. On
glans penis there was a patch of erythema (circinate
balanitis).

Figure 1. Flexion deformities and psoriatic lesions in both
hands; multiple ulcers with undermined edges and purulent
discharge in the groin area, a patch of erythema over glans penis
(circinate balanitis)

Investigations showed hemoglobin 10gm%,
leucocytosis (12500/cmm) with lemphocytosis
(65%) and raised ESR (62mm/hr). Liver function tests
(LFT) were slightly raised i.e. SGOT/PT (85/80). Smear
was made from the groin ulcer and stained for AFB; it
showed the presence of acid fast bacilli. Polymerase
chain reaction (PCR) test was positive for
mycobacterium scrofulaceum, M. avium-
intracellulare, actinomycosis, sporotrichosis,
botryomycosis, nocardiosis, syphilitic gumma and
hidradenitis suppurativa. In our case, swellings
with draining sinuses, presence of acid fast bacilli on
gram staining and positive result on PCR testing
favoured the diagnosis of scrofuloderma.

Psoriasis could represent an independent risk factor
for TB. Up 70% of psoriatic patients require
traditional systemic treatments, such as retinoids,
methotrexate, and cyclosporine. Many of them
import long-term toxicity, treatment resistance,
and potential drug interactions, so only 25% of
psoriatic patients are completely satisfied with their
treatment. Advanced drugs such as TNF-α
inhibitors are associated with an increased risk of
developing active disease in patients with latent
tuberculosis infection (LTBI), because TNF-α is a key
cytokine in protective host defense against
Mycobacterium tuberculosis. Our case also gave
the history of treatment outside with some costly
medication. This could be a TNF-α inhibitor, which
might be responsible for flare up of latent
tuberculosis. For this reason, exclusion of active TB
and treatment of LTBI are, therefore, clinical
imperatives prior to starting anti-TNF-α therapy
and active surveillance for a history of untreated or
partially treated TB or LTBI has already been shown
to be effective in reducing the number of incident
TB cases in psoriatic patients.

CONCLUSION

We conclude that severe psoriasis may be
associated with an increased risk of developing
l atent TB and patient taking systemic corticosteroids, non-steroidal anti-inflammatory drugs and newer drugs in the form of biological agents may be associated with scrofuloderma.

REFERENCES


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