Dermatology Practical & Conceptual

Colchicine-Responsive Granuloma Faciale: A Case Report with Dermoscopic Clues

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Introduction

Granuloma faciale (GF) is a rare, benign inflammatory skin disorder characterized by red-brown or purplish papules, plaques, or nodules generally on the face [1]. The lesions are often asymptomatic and appear in middle-aged white males. The exact cause of GF is unknown. Histopathologically, GF presents with mixed dermal inflammatory infiltration, grenz zone, and vascular damage [2]. Dermoscopy has recently gained importance as a noninvasive diagnostic tool [3]. GF lesions are chronic, and spontaneous healing is rare. The disease is very difficult to treat, and response to treatment is variable [1]. This case report presents a GF case diagnosed via dermoscopy and histopathology, successfully treated with colchicine.

Case Presentation

A 62-year-old male presented with a five-month history of a rash on the nose. He had previously received treatment for rosacea with topical metronidazole and sodium sulfacetamide without improvement. The patient had no systemic disease. Laboratory tests were normal, and the Venereal Disease Research Laboratory (VDRL) test was negative. At dermatological examination, an infiltrated plaque with mild violaceous erythema at the border with scales was observed on the nose. Dermoscopic examination (Dermlite DL5; 3 Gen; polarized, 10x) revealed a red-brown background with yellow follicular openings, irregular white lines, linear branching vessels, brown dots/globules, and occasional scales. The histopathology revealed mixed-type inflammatory cell infiltration involving the entire dermis, with a grenz zone between the epidermis and dermis (Figures 1A–C).

The diagnosis of GF was confirmed clinically, dermoscopically, and histopathologically. The patient was treated with topical steroid, tacrolimus, and systemic colchicine (twice a day). After one month, the lesion began to regress, and by the seventh month, significant improvement was observed (Figure 2). No recurrence was observed during follow-up, and the patient remains under monitoring.

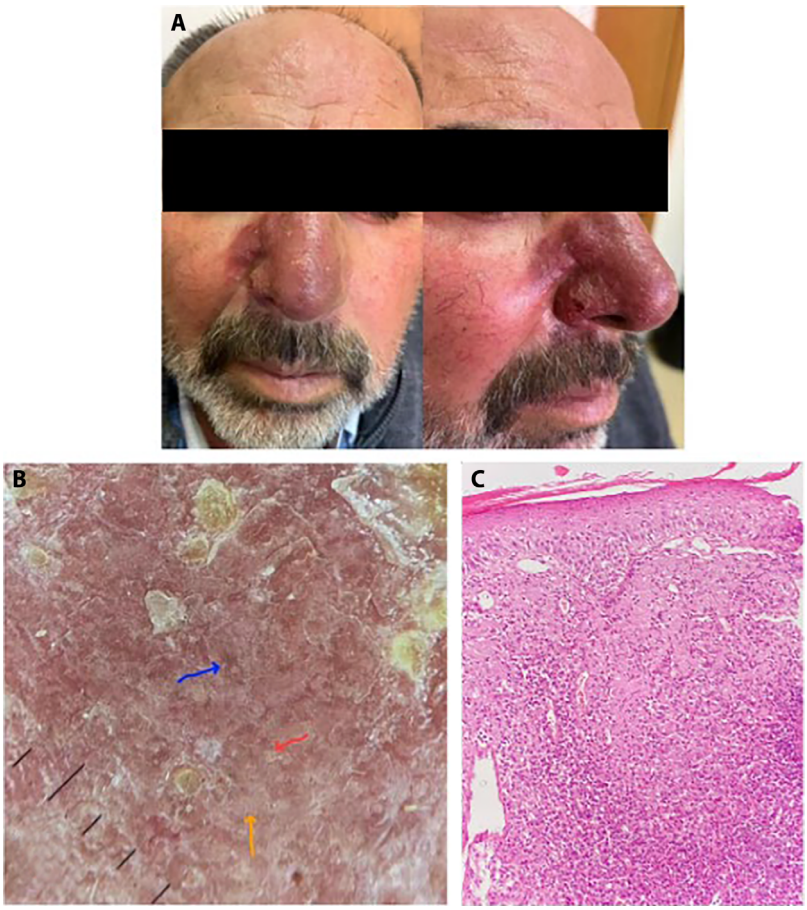

Figure 1. (A) An infiltrated plaque with sharp borders and mild violaceous erythema extending from the right nasal ala to the dorsum of the nose, with desquamation at the edges. (B) Dermoscopic examination: dilated yellow follicles (red arrow) on an erythematous-brown background, scattered brown dots and globules (blue arrow), and irregular white lines (orange arrow). (C) Histopathological examination; widespread inflammation in the dermis rich in eosinophils with histiocytes arranged in a palisading pattern in the upper dermis and plasma cells, separated from the epidermis by a narrow grenz zone (H&E 200x).

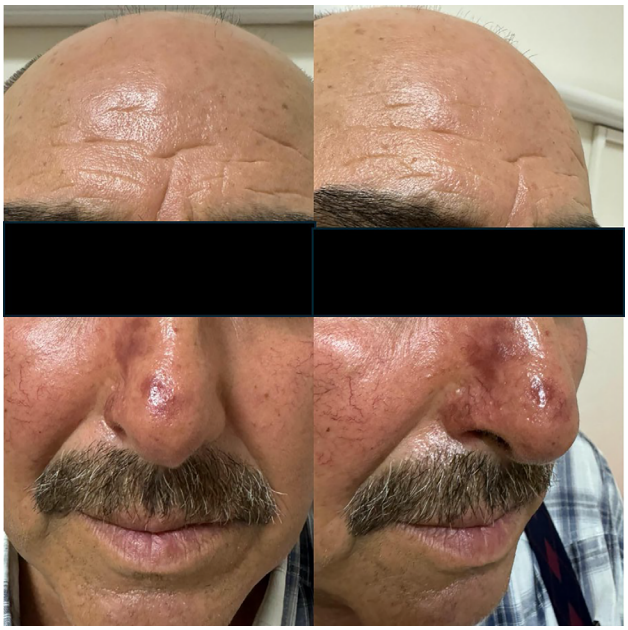

Figure 2. Significant regression of the lesions at 7th month of colchicine treatment.

Conclusions

A skin biopsy is necessary to differentiate GF from conditions like sarcoidosis, discoid lupus erythematosus, and cutaneous lymphoma [2]. Dermoscopy is a valuable, noninvasive method for diagnosing GF and distinguishing it from other similar conditions [3]. In 2012, Caldarola et al. described dermoscopic features of GF [4]. Typical dermoscopic findings for GF include a red-yellow-brown background, scattered brown dots and globules, mildly branching linear vessels, perifollicular white halos, and dilated follicular openings. These findings correlate with histopathology, such as hemosiderin deposition and dermal infiltration [3]. The dermoscopic characteristics of our case were consistent with the literature. Additionally, the scale was more prominent.

GF is usually asymptomatic but can lead to cosmetic concerns due to its chronic course. Common treatment options include topical tacrolimus and corticosteroids, although treatment can sometimes be challenging. Other treatments

reported include intralesional and systemic corticosteroids, topical pimecrolimus, dapsone, hydroxychloroquine, clofazimine, TNF-α inhibitors, laser therapy, cryotherapy, and surgery [1]. Colchicine, though rarely used, has shown promise in treating GF [5]; it inhibits polymorphonuclear leukocyte chemotaxis, prevents lysosome formation, and stabilizes lysosomal membranes, mimicking the anti-inflammatory effects of dapsone [6]. Given its effectiveness and reliability, colchicine could be considered a treatment option for GF.

This case contributes to the literature by providing clinical, dermoscopic, and histopathological findings of GF treated with colchicine.

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