

Visual Treats in Dermatology

## Histoid leprosy – Dermoscopy findings

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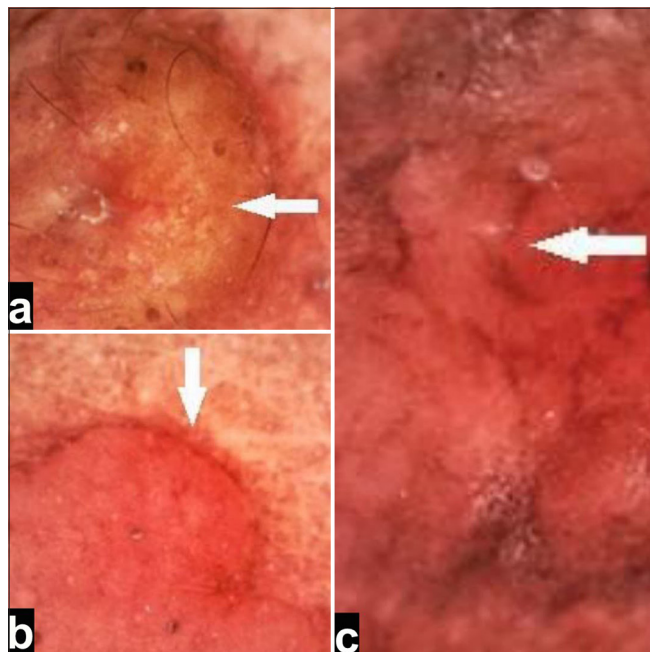
Histoid leprosy (HL), a highly bacilliferous variant of lepromatous leprosy (LL), was first reported in patients who were on dapsone monotherapy, indicative of drug resistance. However, of late *de novo* cases have also been reported. A 58-year-old female presented with paresthesia of bilateral hands and feet and asymptomatic skin lesions of 8 months' duration. The lesions first started on the trunk, and later upper limbs and face were affected. There was no history of diabetes. On examination, the patient had multiple discrete skin coloured shiny succulent papules and plaques arising from an apparently normal skin distributed on the posterior trunk, forearms, and face [Figure 1]. There was no loss of sensation in the skin lesions. There was a glove and stocking type of anesthesia. The ulnar nerve and common peroneal nerves showed grade 1 thickening bilaterally without tenderness. There was no grade 2 disability. Slit skin smear from ear lobes and skin



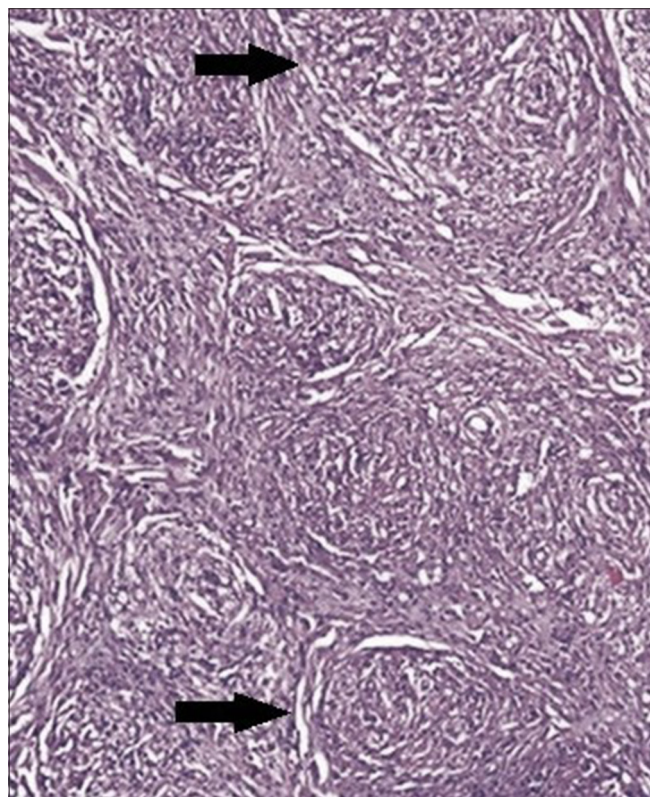
**Figure 1:** Well defined skin coloured shiny succulent papules and plaques of histoid leprosy on the posterior trunk.

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**Figure 2:** (a) Yellowish white structureless areas (white arrow) on dermoscopy. (b) Peripheral brown pigmentation (white arrow). (c) Linear and branched “crown vessels” (white arrow): Dermatitis, polarizing light  $\times 80$ .



**Figure 3:** Skin biopsy showing dermis packed with spindle-shaped histiocytes (black arrow), hematoxylin and eosin  $\times 400$ .

papule showed a Bacterial index of 6+ and a Morphological index of 72%. Dermoscopic examination of the papule and

plaques demonstrated yellowish white structureless areas (corresponding to the granulomas) [Figure 2a], peripheral brownish pigmentation [Figure 2b], and linear and branched vessels “crown vessels” [Figure 2c]. Skin biopsy showed the dermis packed with spindle-shaped histiocytes filled with bacilli diagnostic of HL [Figure 3]. The patient was started on multibacillary multidrug therapy with ofloxacin. It is of paramount importance to clinically distinguish HL from LL as the former may be a manifestation of drug resistance requiring alternate regimes. Skin biopsy is the gold standard, but in situations where it cannot be done, dermoscopy is a viable option.<sup>[1]</sup> Yellowish structureless areas are seen in granulomatous conditions, including LL, whereas yellowish white areas are seen in HL, as in our case. The white area is due to the dense packing of spindle-shaped histiocytes in HL, not seen in LL.<sup>[2]</sup> The peripheral rim of brownish pigmentation, again seen in our case, is not seen in LL, is attributed to the well-defined lesions arising from an apparently normal skin.<sup>[2]</sup> The close differentials are dermatofibroma and sarcoidosis. Dermatofibroma also presents histologically with spindle-shaped histiocytes in a storiform pattern, but the Wade-Fite stain will be negative, and *CD34* will be positive. Sarcoidosis classically presents with “naked granulomas” and can be easily distinguished from HL. Hence, dermoscopy can be used to distinguish HL from LL without a skin biopsy.

**Ethical approval:** Institutional Review Board approval is not required.

**Declaration of patient consent:** The authors certify that they have obtained all appropriate patient consent forms. In the form, the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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## REFERENCES

1. Vinay K, Kamat D, Chatterjee D, Narang T, Dogra S. Dermatoscopy in leprosy and its correlation with clinical spectrum and histopathology: A prospective observational study. *J Eur Acad Dermatol Venereol* 2019;33:1947-51.
2. Ankad B, Sharma A, Vinay K, Rathod S, Mehta H, Bhat YJ, *et al.* Dermoscopic evaluation of leprosy: A multi-centre cross-sectional study. *Indian J Dermatol Venereol Leprol* 2024;90:486-93.

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