Rosacea Fulminans–A Diagnosis to Remember

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Abstract

Rosacea fulminans is a rare condition, mainly affects young women, with an unknown etiology. Its main differential diagnosis is acne fulminans. We report this rare condition that presented good clinical evolution after the use of antibiotic and corticosteroid therapy.

Keywords: Rosacea fulminans • Ceftriaxone • Corticotherapy

Introduction

Rosacea fulminans is a rare condition that was described in 1940 by O'Leary initially called Pyoderma Facialis [1]. It is characterized by the sudden appearance of papules, pustules, cystic lesions distributed on the face, predominantly in the central facial region. It mainly affects young women, with an unknown etiology [2]. Its main differential diagnosis is acne fulminans. In the literature, the recommended treatment is corticotherapy and isotretinoin as the first choice [3].

We report this rare condition that presented good clinical evolution and therapeutic response with the use of antibiotic therapy (Ceftriaxone and Oxacillin for 10 days) and corticosteroid therapy (hydrocortisone for 10 days).

Case Report

A 49-year-old female presented with intermittent painful and pruritic malar papules and pustules for 2 years. It evolved with progressive worsening of the condition, affecting the entire central facial region, covered by yellowish crusts and associated facial edema (Figure 1). She reported burning at the site, denied fever and complained of blurred vision. Hospitalization was chosen, all infectious, metabolic and autoimmune investigations were carried out, with negative results. Treatment with Ceftriaxone and Oxacillin and prednisone was started, and a skin biopsy was performed (Figures 2A and 2B). The patient evolved with an improvement in the skin condition and during the outpatient follow-up we maintained antibiotic therapy.

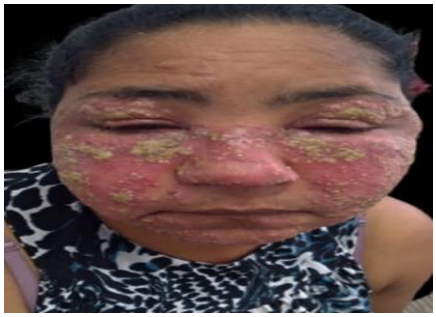

Figure 1. Papules and erythematous plaques covered by infiltrated yellowish crusts, distributed in the central facial region.

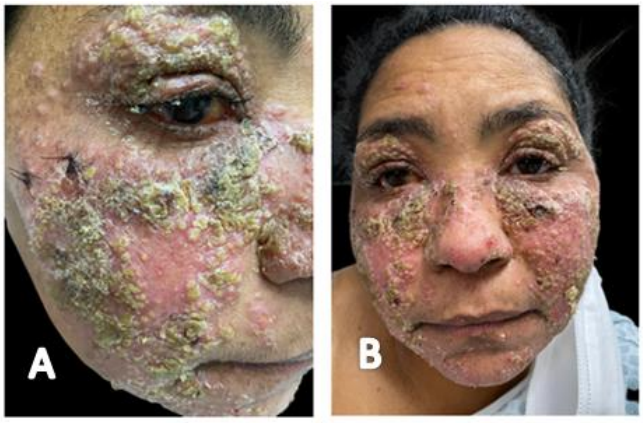

Figure 2A & 2B. Mild conjunctival erythema; papules and erythematous plaques covered by meliceric crusts affecting the center of the face and eyelid region.

Based on the clinical condition and the anatomopathological findings (Figures 3 and 4), we arrived at the diagnosis of Rosacea Fulminans; due to the good clinical evolution of the patient, we maintained oral antibiotic therapy (Bactrim followed by the use of Doxycycline) (Figure 5A, 5B).

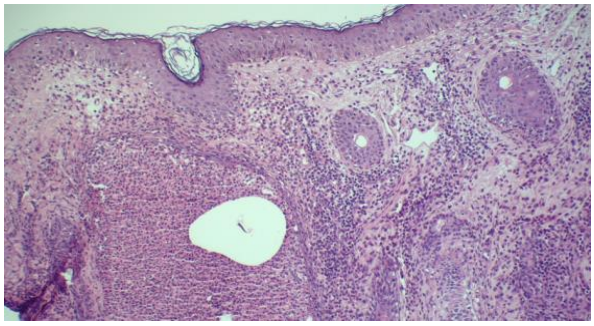

Figure 3. Higher increase (40x) observes follicular dilitation with destruction and formation of microabscesses containing neutrophils

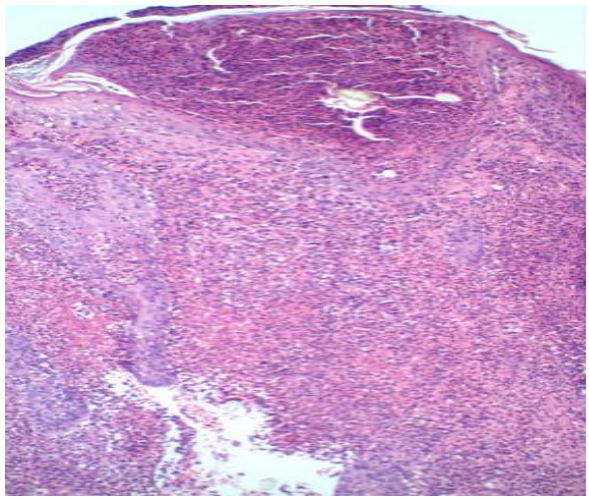

Figure 4. (40x increase) Follicular destruction is observed with the presence of netrophil aggregates forming microabscesses in the infundibular region. a pulse can be observed in this cut corresponding to the finding seen in the clinic. in addition to a dense neutrophilic infiltrate in the dermis.

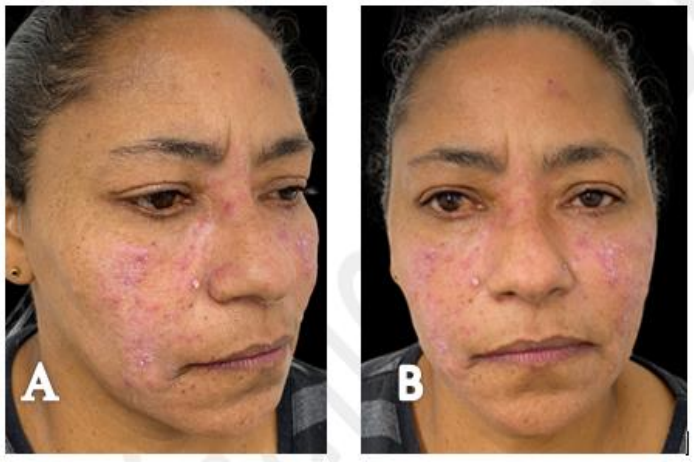

Figure 5A & 5B. Follicle showing dermal papilla injury.

Discussion

Rosacea Fulminans has a strong predominance in females, aged between 20 years and 40 years. The most affected site is the facial center, and may affect the extra facial area. No systemic symptoms or the presence of comedones are observed [4]. The pathophysiology of this dermatosis is not yet well established, being associated with hormonal changes such as menopause, pregnancy or changes in oral contraceptives. There is also a relationship with emotional trauma and a neurovascular dysregulation, as seen in some subtypes of rosacea. The clinical manifestation is characterized by the sudden appearance of papules, pustules and nodules with cyanotic erythema restricted to the face. Among the differential diagnoses we observed bacterial folliculitis, acne fulminans, Sweet facial syndrome, granulomatous rosacea [5].

Conclusion

The treatment reported in the literature starts with oral corticosteroids followed by the introduction of isotretinoin to prevent relapses, there are reports of association with oral antibiotics, but there were no significant results. In the case reported, we can observe a good response with oral antibiotics and corticosteroids, maintaining antibiotic therapy for outpatient follow-up.

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