Clinical Image
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Granuloma Annulare

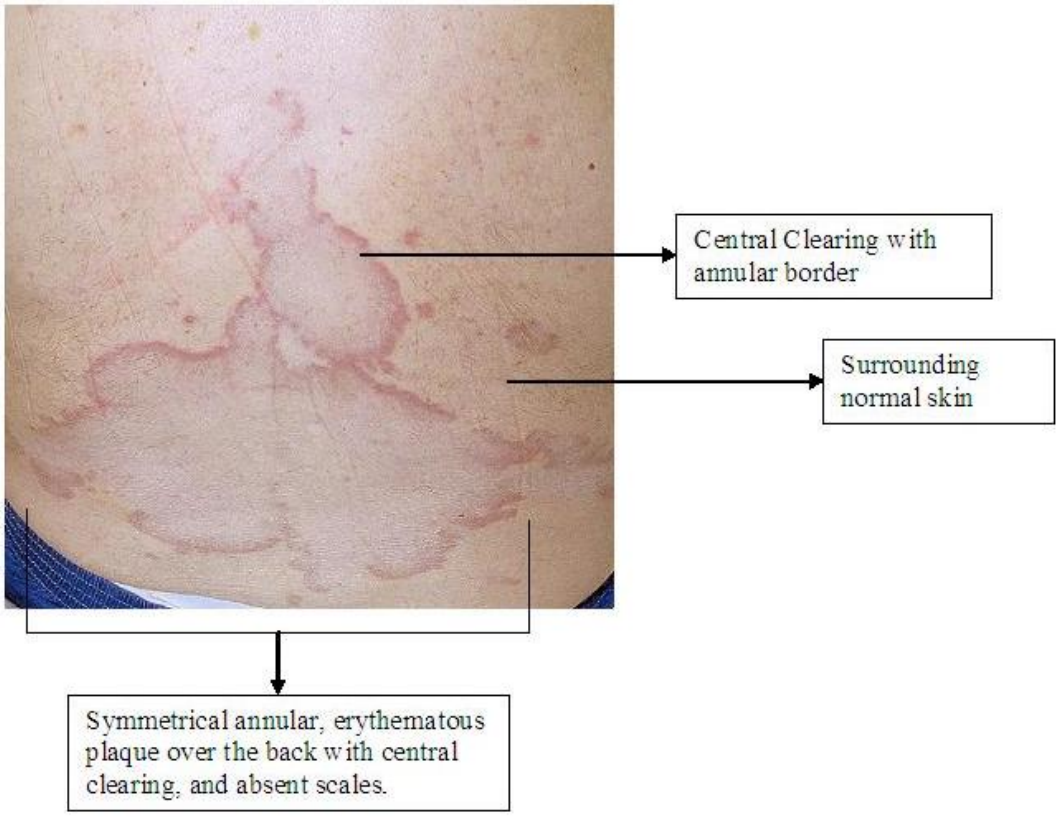

FIGURE 1. Back of the patient.

Diptesh Gupta[1,*], Brian Hess[2], and Lohith Bachegowda[3]

[1]Department of Internal Medicine, University of Missouri – Columbia; [2]MU School of Medicine, Columbia, MO; [3]Department of Internal Medicine, Drexel University, Philadelphia

E mail: guptadi@health.missouri.edu; hessb@missouri.edu; Lohith.Shakaldevanapura@DrexelMed.edu

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*Corresponding author.

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We present a case of a 77-year-old, diabetic male with a 20-year history of a migratory erythematous, asymptomatic, generalized, nonscaly, and nonitchy rash that started over the dorsum of his left hand. On examination, there were multiple annular erythematous plaques, distributed symmetrically and diffusely over his torso and arms, with central clearing and no scales (Figs. 1–3). He was empirically treated with topical antifungals with no improvement. A potassium hydroxide (KOH) microscopic slide was prepared, which yielded a negative result for a fungal infection. A punch biopsy of the skin helped us to arrive at the diagnosis of a generalized granuloma annulare (GA).

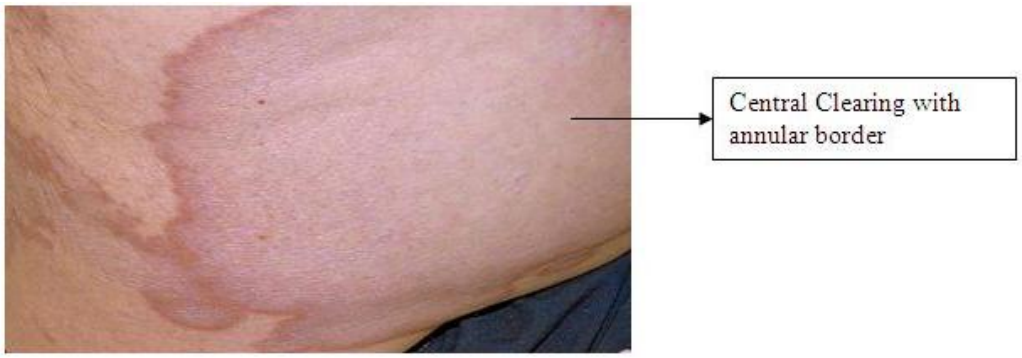

FIGURE 2. Right flank.

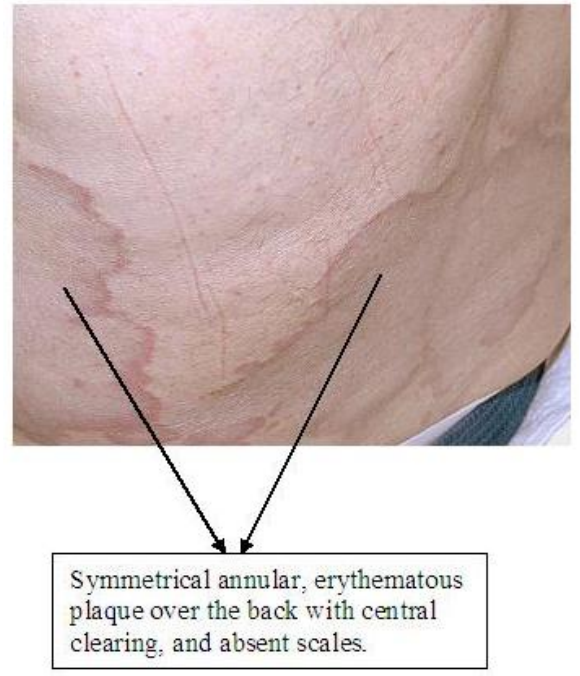

FIGURE 3. Left flank. Note the symmetrical distribution of the rash.

GA is a benign, self-limiting skin condition of unknown etiology that is often asymptomatic, but can rarely be associated with mild pruritus[1]. Women are twice as likely to have GA as compared to men[2]. The cause of this condition is unknown, but it has been associated with diabetes mellitus, infections such

as HIV, and malignancies such as lymphoma. These lesions typically start as a ring of flesh-colored papules that slowly progress with central clearing[1]. Lack of symptoms, scaling, or associated vesicles helps to differentiate GA from other skin conditions such as tinea corporis, pityriasis rosea, psoriasis, or erythema annulare centrifugum[4,5]. The KOH slide preparation and a punch biopsy helped to confirm the diagnosis[3,4]. Treatment is often not needed as the majority of these lesions are self-resolving within 2 years[1]. Treatment may be pursued for cosmetic reasons. Available options include high-dose steroid creams, PUVA, cryotherapy, or drugs such as niacinamide, infliximab, Dapsone, and topical calcineurin inhibitors[1,5].

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