Case: A 48-year-old incarcerated male with no significant past medical history presented to dermatology clinic with a six-month history of a pruritic erythematous rash involving the occipital scalp and bilateral knees. The patient had previously trialed topical triamcinolone without improvement. Physical examination was significant for well-defined erythematous plaques with minimal scale over the extensor surfaces of the knees, lower legs, and arms. Given the extensor distribution and scale, psoriasis was initially favored, though sarcoidosis and granuloma annulare remained in the differential. The patient was started on clobetasol 0.05% cream twice daily and a punch biopsy of the left thigh was performed. Histopathology results demonstrated granulomatous dermatitis with noncaseating "naked" granulomas consistent with sarcoidosis, and a Chest X-ray was ordered. At follow-up, the patient reported minimal improvement with clobetasol and continued progression of lesions. His updated physical exam demonstrated multiple yellow-brown to violaceous, slightly indurated annular plaques involving the extensor surfaces of the arms, legs, hands, and occipital scalp. Hydroxychloroquine 200 mg twice daily and doxycycline 100 mg twice daily were initiated, and the patient was referred to ophthalmology for baseline evaluation. Ophthalmologic evaluation showed no ocular involvement. A CT chest and EKG were obtained as part of systemic evaluation, which revealed pulmonary nodules concerning stage III pulmonary sarcoidosis. These findings confirmed systemic involvement and prompted multidisciplinary evaluation. The patient later reported development of new lesions around the neck which he attributed to hydroxychloroquine, and the medication was discontinued. He completed three months of doxycycline therapy with improvement in cutaneous lesions. In February 2026, the patient was evaluated by rheumatology and laboratory evaluation including ACE, lysozyme, and 1,25-dihydroxyvitamin D levels were within normal limits. In March 2026, the patient returned to the dermatology clinic with concern for deeper cutaneous lesions. A punch biopsy of a deeper lesion on the left forearm was obtained to evaluate for deep cutaneous sarcoidosis, and referral to pulmonology and cardiology was arranged for further systemic evaluation (results pending).

Discussion:

Sarcoidosis is a systemic inflammatory disease that can affect any organ, with pulmonary involvement being the most common (90%).[1] It is characterized by noncaseating granuloma formation. Sarcoidosis is most commonly diagnosed in young to middle-aged adults, and most patients are identified with thoracic involvement. In one-third of cases, cutaneous sarcoidosis occurs and presents with red-brown papules and plaques. Cutaneous sarcoidosis is often referred to as the "great imitator," as it can mimic discoid lupus erythematosus, lichenoid dermatitis, psoriasis, and infections.[2] Skin biopsy is the safest and least invasive way to make diagnoses. When someone is diagnosed with cutaneous sarcoidosis, comprehensive systemic evaluation is mandatory as 30%-40% of patients have asymptomatic systemic disease. The following baseline tests should be ordered: CBC, Chest X-ray, ECG, ophthalmologic screening, and Tuberculosis screening.[3] Additionally, with this patient there was concern for deep cutaneous sarcoidosis, which primarily affects subcutaneous tissue and is associated with a more favorable prognosis. In contrast, superficial cutaneous sarcoidosis involves the dermis and is strongly associated with chronic systemic disease.[4] The treatment for cutaneous sarcoidosis is stepwise. In limited cutaneous disease, topical steroids can be initiated.[5] If systemic therapy is required, hydroxychloroquine combined with topical steroids is offered. Similar to this case, in some steroid refractory cases tetracyclines such as doxycycline can be used due to their anti-inflammatory and granuloma inhibiting properties.[6] This case highlights the importance of dermatologic screening as a gateway to larger systemic diagnoses. The patient's concern for his cutaneous symptoms urged him to follow with a telehealth dermatology clinic, allowing his baseline screening to be done early in his disease course and initiate management.

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