

## Background

- Sarcoidosis is a systemic granulomatous inflammatory disease
- Most commonly affects the lungs
- Approximately one-third of patients develop cutaneous manifestations<sup>2</sup>
- 30–40% of patients with cutaneous sarcoidosis have asymptomatic systemic involvement → early detection is critical

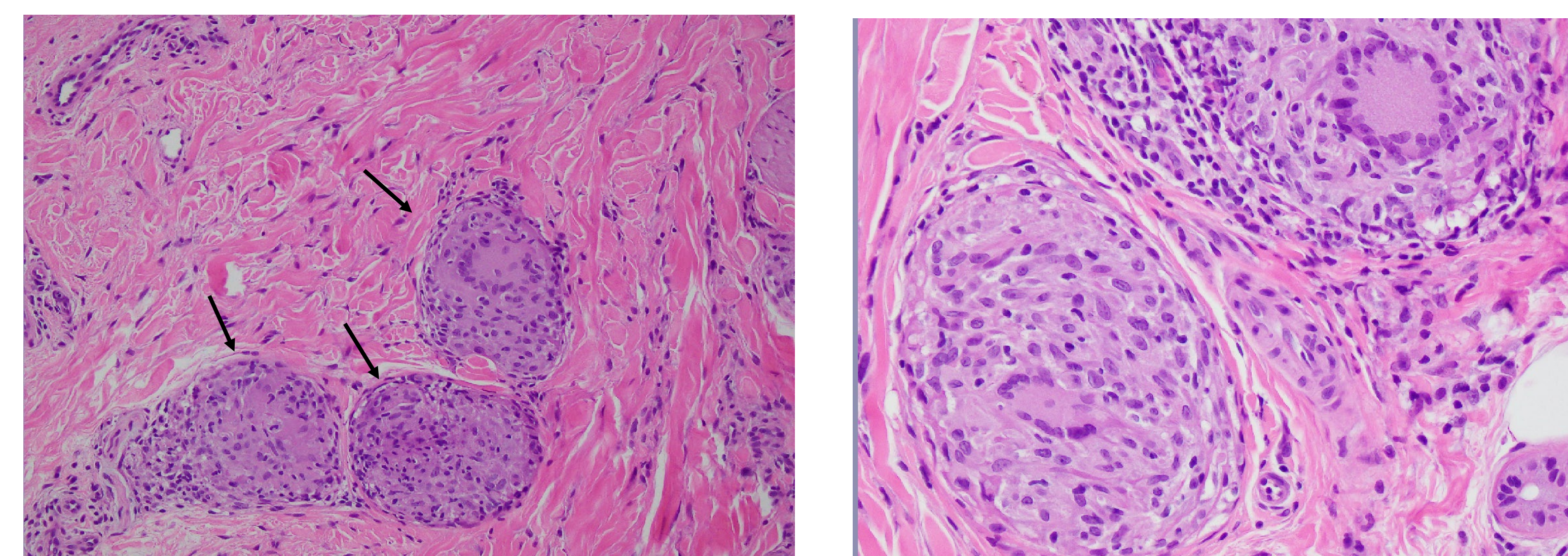
## Case Presentation

- 48-year-old incarcerated African American male with no significant past medical history
- 6-month history of pruritic erythematous rash involving the occipital scalp and bilateral knees.
- Physical Exam: well-defined erythematous plaques with minimal scale over the extensor surfaces of the knees, lower legs, and arms (**Fig 1**).
- Treated with clobetasol 0.05% cream twice daily; punch biopsy of left thigh obtained
- Histopathology: granulomatous dermatitis with **noncaseating “naked” granulomas** consistent with sarcoidosis (**Fig 2**).
- 5 months later, minimal improvement with clobetasol and continued progression of lesions.
- Physical exam: 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 initiated
- Baseline ophthalmologic evaluation obtained with no ocular involvement.
- A CT chest and EKG obtained as part of systemic evaluation revealed pulmonary nodules concerning for stage III pulmonary sarcoidosis (**Fig 3**)
- Several months later, per patient new lesions around the neck attributed to hydroxychloroquine → discontinued.
- Physical examination showed great improvement in lesions, continued doxycycline therapy
- February 2026, rheumatologic evaluation with no concerns
- March 2026, concern for deeper lesions
- Punch biopsy of a forearm lesion was obtained to evaluate for deep cutaneous sarcoidosis with referral to pulmonology and cardiology for further systemic evaluation (results pending).

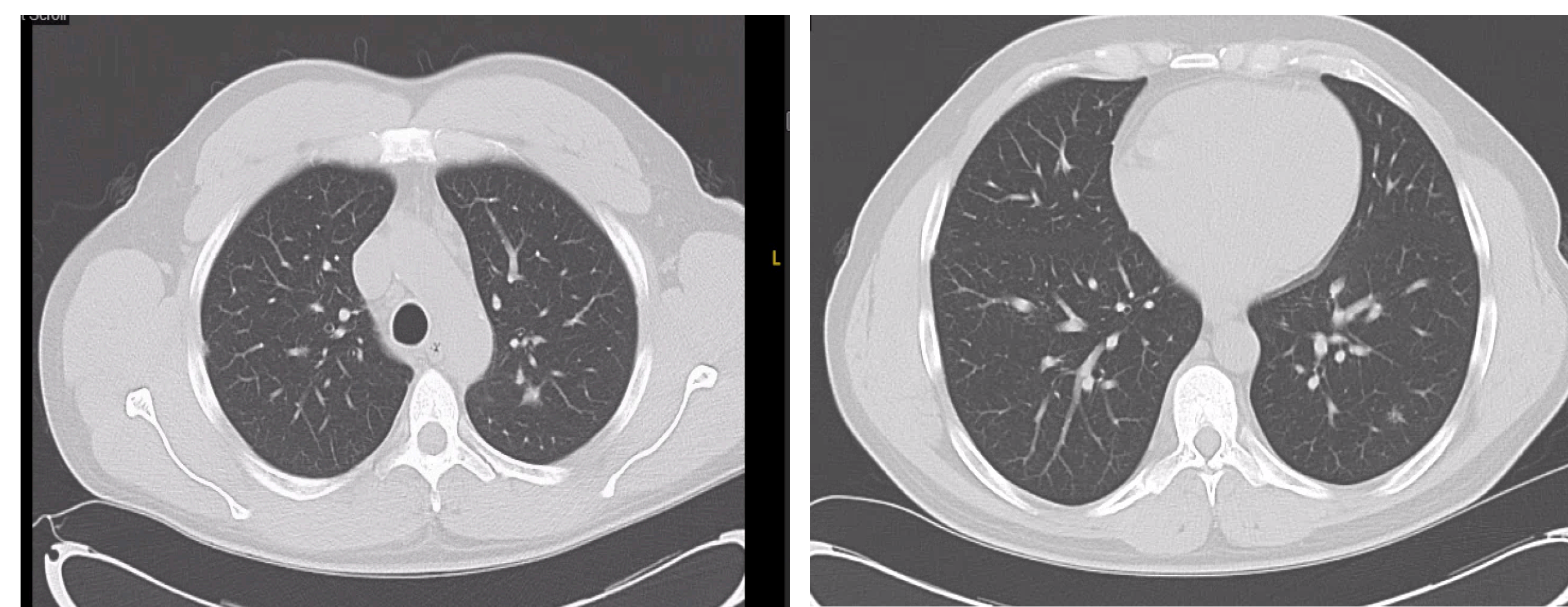
## Clinical and Pathological Images



**Fig 1:** Violaceous to yellow-brown indurated plaques and nodular lesions involving the extensor surfaces of the upper and lower extremities, including the elbow and knee. These lesions were present at initial examination. **Patient identity has been concealed, and informed consent for clinical photography and publication was obtained.**



**Fig 2:** Histopathology from left thigh punch biopsy demonstrating granulomatous dermatitis with noncaseating “naked” granulomas (arrows) at 200× (left) and 400× (right). Special stains, including AFB, GMS, and PAS, were negative for infectious organisms.



**Fig 3:** Chest CT, showing multiple bilateral pulmonary nodules concerning for stage III pulmonary sarcoidosis identified during systemic evaluation.

## Discussion

- Dermatologic screening is a gateway to larger systemic diagnoses.
- Cutaneous symptoms prompted early systemic evaluation and initiation of management.
- Baseline evaluation: CBC, Chest X-ray, ECG, ophthalmologic screening, and Tuberculosis screening.<sup>3</sup>
- Deep cutaneous sarcoidosis primarily affects subcutaneous tissue and is associated with a more favorable prognosis.
- Superficial cutaneous sarcoidosis involves the dermis and is strongly associated with chronic systemic disease.<sup>4</sup>
- Treatments for cutaneous sarcoidosis is stepwise.
  - In limited cutaneous disease, topical steroids can be initiated.<sup>5</sup>
  - If systemic therapy is required, hydroxychloroquine combined with topical steroids is offered.
  - In some steroid refractory cases, tetracyclines such as doxycycline can be used due to their anti-inflammatory and granuloma inhibiting properties.<sup>6</sup>
- Early dermatologic recognition of cutaneous sarcoidosis is critical, as it may serve as the first indication of systemic disease requiring multidisciplinary evaluation.

## References

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